TABLE 1 TO PARAGRAPH (a)—Continued

Commodity	Parts per million
Bean, yellow, dry seed	0.04
Berry, low growing, subgroup 13–07G	4.0
Bushberry subgroup 13–07B	5.0
Caneberry subgroup 13–07A	4.0
Canola, refined oil	0.03
Cherry subgroup 12–12A	4.0
Chickpea, dry seed	0.04
Chickpea, edible podded	1.5
Chickpea, succulent shelled	0.04
Cowpea, dry seed	0.04
Cowpea, edible podded	0.6
Cowpea, succulent shelled	0.04
Edible podded pea, edible podded	1.5
Flax, seed, oil	0.03
Fruit, pome, group 11–10	0.60
Fruit, small vine climbing, except fuzzy kiwifruit, subgroup 13–07F	3.0
Fruit, small vine climbing, except grape, subgroup 13–07E	10.0
Ginseng	3
Gram, horse, dry seed	0.04
Grape, raisin	5.0
Grass pea, dry seed	0.04
Grass pea, edible podded	1.5
Jackbean, dry seed	0.04
Jackbean, edible podded	0.6
Jackbean, succulent shelled	0.04
Lentil, dry seed	0.04
Lentil, edible podded	1.5
Lentil, succulent shelled	0.04
Lettuce, head	5.0
Lettuce, leaf	7.0
Longbean, Chinese, dry seed	0.04
Longbean, Chinese, edible podded	0.6
Lupin, Andean, dry seed	0.04
Lupin, Andean, succulent shelled	0.04
Lupin, blue, dry seed	0.04
Lupin, blue, succulent shelled	0.04
Lupin, grain, dry seed	0.04
Lupin, grain, succulent shelled	0.04
Lupin, sweet white, dry seed	0.04
Lupin, sweet white, succulent shelled	0.04
Lupin, sweet, dry seed	0.04
Lupin, sweet, succulent shelled	0.04
Lupin, white, dry seed	0.04
Lupin, white, succulent shelled	0.04
Lupin, yellow, dry seed	0.04
Lupin, yellow, succulent shelled	0.04
Mustard, seed, oil	0.03
Pea, blackeyed, succulent shelled	0.04
Pea, crowder, dry seed	0.04
Pea, crowder, succulent shelled	0.04
Pea, dry, dry seed	0.04
Pea, dwarf, edible podded	1.5

TABLE 1 TO PARAGRAPH (a)—Continued

Commodity	Parts per million
Pea, English, succulent shelled	0.04
Pea, field, dry seed	0.04
Pea, garden, dry seed	0.04
Pea, garden, succulent shelled	0.04
Pea, green, dry seed	0.04
Pea, green, edible podded	1.5
Pea, green, succulent shelled	0.04
Pea, pigeon, dry seed	0.04
Pea, pigeon, edible podded	1.5
Pea, pigeon, succulent shelled	0.04
Pea, snap, edible podded	1.5
Pea, snow, edible podded	1.5
Pea, southern, succulent shelled	0.04
Pea, sugar snap, edible podded	1.5
Pea, winged, dry seed	0.04
Pea, winged, edible podded	0.6
Peach subgroup 12–12B	3.0
Plum subgroup 12–12C	0.80
Plum, Prune, Dried	1.50
Rapeseed subgroup 20A	0.015
Sesame, oil	0.03
Soybean, vegetable, dry seed	0.04
Soybean, vegetable, edible podded	0.6
Soybean, vegetable, succulent shelled	0.04
Velvetbean, dry seed	0.04
Velvetbean, edible podded	0.6
Velvetbean, succulent shelled	0.04
Yam bean, African, dry seed	0.04

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1773–F]

RIN 0938–AU83

Medicare Program; FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This rule updates the hospice wage index, payment rates, and aggregate cap amount for Fiscal Year (FY) 2023. This final rule establishes a permanent mitigation policy to smooth the impact of year-to-year changes in hospice payments related to changes in the hospice wage index. In addition, this rule updates the Hospice Quality Reporting Program (HQRP) and discusses further development of the Hospice Outcomes and Patient Evaluation (HOPE) assessment instrument; updates the Quality Measures (QMs) that will be in effect in FY 2023 for the HQRP and future QMs; updates the Consumer Assessment of Healthcare Providers and Systems, Hospice Survey Mode Experiment, discusses a request for information on health equity, and updates the hospice survey and enforcement procedures.

DATES: These regulations are effective on October 1, 2022.

FOR FURTHER INFORMATION CONTACT:

For general questions about hospice payment policy, send your inquiry via email to: *hospicepolicy@cms.hhs.gov.*

For questions regarding the CAHPS® Hospice Survey, contact Lori Teichman at (410) 786–6684 and Lauren Fuentes at (410) 786–2290.

For questions regarding the hospice quality reporting program, contact Cindy Massuda at (410) 786–0652.

For information regarding the hospice special focus program, send your inquiry via email to *QSOG_hospice@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Executive Summary

This final rule updates the hospice wage index, hospice payment rates, and aggregate cap amount for FY 2023, as required under section 1814(i) of the Social Security Act (the Act). This rule also finalizes the permanent mitigation policy to smooth the impact of year-to-year changes in hospice payments related to changes in the hospice wage index. In addition, in this final rule, CMS discusses updates to the Hospice Quality Reporting Program (HQRP) that include the Hospice Outcomes and Patient Evaluation (HOPE) with national beta testing; the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey with Star Ratings; developing a web-based survey; Public Reporting; a request for information that builds from last year's discussion on health equity, updates on advancing a health information exchange, and updates on hospice survey and enforcement procedures.

II. Background

A. Hospice Care

Hospice care is a comprehensive, holistic approach to treatment that

recognizes the impending death of a terminally ill individual and warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. Medicare regulations define ''palliative care'' as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (42 CFR 418.3). Palliative care is at the core of hospice philosophy and care practices, and is a critical component of the Medicare hospice benefit.

The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through a collaboration of professionals and other caregivers, with the goal of making the beneficiary as physically and emotionally comfortable as possible. Hospice provides compassionate beneficiary and family/caregiver-centered care for those who are terminally ill.

As referenced in our regulations at § 418.22(b)(1), to be eligible for Medicare hospice services, the patient's attending physician (if any) and the hospice medical director must certify that the individual is ''terminally ill,'' as defined in section 1861(dd)(3)(A) of the Act and our regulations at § 418.3; that is, the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. The regulations at § 418.22(b)(2) require that clinical information and other documentation that support the medical prognosis accompany the certification and be filed in the medical record with it. Additionally, the regulations at § 418.22(b)(3) require that the certification and recertification forms include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

Under the Medicare hospice benefit, once a terminally ill patient elects to receive hospice care, a hospice interdisciplinary group (IDG) is essential in ensuring the provision of primarily home-based services, keeping the choices of the patient and family first and foremost. The hospice IDG works with the beneficiary, family, and caregiver(s) to develop a coordinated, comprehensive care plan; reduce unnecessary diagnostics or ineffective therapies; and maintain ongoing communication with individuals and their families about changes in their condition and care. The beneficiary's care plan will shift over time to meet the changing needs of the individual, family, and caregiver(s) as the individual approaches the end of life.

If, in the judgment of the hospice IDG, which includes the hospice physician, the patient's symptoms cannot be effectively managed at home, then the patient is eligible for general inpatient care (GIP), a more medically intense level of care. GIP must be provided in a Medicare-certified hospice freestanding facility, skilled nursing facility, or hospital. GIP is provided to ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to their home and continue to receive routine home care (RHC). Limited, short-term, intermittent, inpatient respite care (IRC) is also available to provide relief for the family or other caregivers, or when the family or other caregivers are absent. Additionally, an individual can receive continuous home care (CHC) during a period of crisis, in which an individual requires continuous care to achieve palliation or management of acute medical symptoms so that the individual can remain at home. CHC may be covered for as much as 24 hours a day, and these periods must be predominantly nursing care, in accordance with the regulations at § 418.204. A minimum of 8 hours of nursing care, or nursing and aide care, must be furnished on a particular day to qualify for the CHC rate (§ 418.302(e)(4)).

Hospices must comply with applicable civil rights laws,[1] including section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, under which covered entities must take appropriate steps to ensure effective communication with patients and patient care representatives with disabilities, including the provisions of auxiliary aids and services. In addition, they must take reasonable steps to ensure meaningful access for individuals with limited English proficiency, consistent with Title VI of the Civil Rights Act of 1964. Further information about these requirements may be found at: *http://www.hhs.gov/ocr/civilrights.*

[1] Hospices are also subject to additional Federal civil rights laws, including the Age Discrimination Act, Section 1557 of the Affordable Care Act, and conscience and religious freedom laws.

B. Services Covered by the Medicare Hospice Benefit

Coverage under the Medicare hospice benefit requires that hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. Section 1861(dd)(1) of the Act establishes the services that are to be rendered by a Medicare-certified hospice program. These covered services include: nursing care; physical therapy; occupational therapy; speech-language pathology therapy; medical social services; home health aide services (called hospice aide services); physician services; homemaker services; medical supplies (including drugs and biologicals); medical appliances; counseling services (including dietary counseling); short-term inpatient care in a hospital, nursing facility, or hospice inpatient facility (including both respite care and procedures necessary for pain control and acute or chronic symptom management); continuous home care during periods of crisis, and only as necessary to maintain the terminally ill individual at home; and any other item or service, which is specified in the plan of care and for which payment may otherwise be made under Medicare in accordance with Title XVIII of the Act.

Section 1814(a)(7)(B) of the Act requires that a written plan for providing hospice care to a beneficiary who is a hospice patient be established before care is provided by, or under arrangements made by, the hospice program; and that the written plan be periodically reviewed by the beneficiary's attending physician (if any), the hospice medical director, and an interdisciplinary group (section 1861(dd)(2)(B) of the Act). The services offered under the Medicare hospice benefit must be available to beneficiaries as needed, 24 hours a day, 7 days a week (section 1861(dd)(2)(A)(i) of the Act).

Upon the implementation of the hospice benefit, the Congress also expected hospices to continue to use volunteer services, though Medicare does not pay for these volunteer services (section 1861(dd)(2)(E) of the Act). As stated in the FY 1983 Hospice Wage Index and Rate Update proposed rule (48 FR 38149), the hospice must have an interdisciplinary group composed of paid hospice employees as well as hospice volunteers, and that ''the hospice benefit and the resulting Medicare reimbursement is not intended to diminish the voluntary spirit of hospices.'' This expectation supports the hospice philosophy of community based, holistic,

comprehensive, and compassionate end of life care.

C. Medicare Payment and Quality for Hospice Care

Sections 1812(d), 1813(a)(4), 1814(a)(7), 1814(i), and 1861(dd) of the Act, and the regulations in 42 CFR part 418, establish eligibility requirements, payment standards and procedures; define covered services; and delineate the conditions a hospice must meet to be approved for participation in the Medicare program. Part 418, subpart G, provides for a per diem payment based on one of four prospectively-determined rate categories of hospice care (RHC, CHC, IRC, and GIP), based on each day a qualified Medicare beneficiary is under hospice care (once the individual has elected). This per diem payment is meant to cover all of the hospice services and items needed to manage the beneficiary's care, as required by section 1861(dd)(1) of the Act.

While recent news reports [2] have brought to light the potential role hospices could play in medical aid in dying (MAID) where such practices have been legalized in certain states, we wish to remind hospices that the Assisted Suicide Funding Restriction Act of 1997 (Pub. L. 105–12) prohibits the use of Federal funds to provide or pay for any health care item or service or health benefit coverage for the purpose of causing, or assisting to cause, the death of any individual including mercy killing, euthanasia, or assisted suicide. This means that while payments made to hospices are to cover all items, services, and drugs for the palliation and management of the terminal illness and related conditions, Federal funds cannot be used for the prohibited activities, even in the context of a per diem payment. However, the prohibition does not pertain to the provision of an item or service for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as the item or service is not furnished for the specific purpose of causing or accelerating death.

1. Omnibus Budget Reconciliation Act of 1989

Section 6005(a) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) amended section 1814(i)(1)(C) of the Act and provided changes in the methodology concerning updating the daily payment rates based on the hospital market basket percentage increase applied to the payment rates in effect during the previous Federal fiscal year.

2. Balanced Budget Act of 1997

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) established that updates to the hospice payment rates beginning FY 2002 and in subsequent FYs are to be the hospital market basket percentage increase for the current FY. Section 4442 of the BBA amended section 1814(i)(2) of the Act, effective for services furnished on or after October 1, 1997, to require that hospices submit claims for payment for hospice care furnished in an individual's home only on the basis of the geographic location at which the service is furnished. Previously, local wage index values were applied based on the geographic location of the hospice provider, regardless of where the hospice care was furnished. Section 4443 of the BBA amended sections 1812(a)(4) and 1812(d)(1) of the Act to provide for hospice benefit periods of two 90-day periods, followed by an unlimited number of 60-day periods.

3. FY 1998 Hospice Wage Index Final Rule

The FY 1998 Hospice Wage Index final rule (62 FR 42860) implemented a new methodology for calculating the hospice wage index and instituted an annual Budget Neutrality Adjustment Factor (BNAF) so aggregate Medicare payments to hospices would remain budget neutral to payments calculated using the 1983 wage index.

4. FY 2010 Hospice Wage Index Final Rule

The FY 2010 Hospice Wage Index and Rate Update final rule (74 FR 39384) instituted an incremental 7-year phase-out of the BNAF beginning in FY 2010 through FY 2016. The BNAF phase-out reduced the amount of the BNAF increase applied to the hospice wage index value, but was not a reduction in the hospice wage index value itself or in the hospice payment rates.

5. The Affordable Care Act

Starting with FY 2013 (and in subsequent FYs), the market basket percentage update under the hospice payment system referenced in sections 1814(i)(1)(C)(ii)(VII) and 1814(i)(1)(C)(iii) of the Act are subject to annual reductions related to changes in economy-wide productivity, as specified in section 1814(i)(1)(C)(iv) of the Act.

In addition, sections 1814(i)(5)(A) through (C) of the Act, as added by section 3132(a) of the Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111–148), required hospices to begin submitting quality data, based on measures specified by the Secretary of the Department of Health and Human Services (the Secretary) for FY 2014 and subsequent FYs. Since FY 2014, hospices that fail to report quality data have their market basket percentage increase reduced by 2 percentage points. Note that with the passage of the Consolidated Appropriations Act, 2021 (hereafter referred to as CAA 2021) (Pub. L. 116–260), the reduction changes to 4 percentage points beginning in FY 2024.

Section 1814(a)(7)(D)(i) of the Act, as added by section 3132(b)(2) of the PPACA, required, effective January 1, 2011, that a hospice physician or nurse practitioner have a face-to-face encounter with the beneficiary to determine continued eligibility of the beneficiary's hospice care prior to the 180th day recertification and each subsequent recertification, and to attest that such visit took place. When implementing this provision, the Centers for Medicare & Medicaid Services (CMS) finalized in the FY 2011 Hospice Wage Index final rule (75 FR 70435) that the 180th day recertification and subsequent recertifications would correspond to the beneficiary's third or subsequent benefit periods. Further, section 1814(i)(6) of the Act, as added by section 3132(a)(1)(B) of the PPACA, authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes. The types of data and information suggested in the ACA could capture accurate resource utilization, which could be collected on claims, cost reports, and possibly other mechanisms, as the Secretary determined to be appropriate. The data collected could be used to revise the methodology for determining the payment rates for RHC and other services included in hospice care, no earlier than October 1, 2013, as described in section 1814(i)(6)(D) of the Act. In addition, CMS was required to consult with hospice programs and the Medicare Payment Advisory Commission (MedPAC) regarding additional data collection and payment revision options.

6. FY 2012 Hospice Wage Index Final Rule

In the FY 2012 Hospice Wage Index final rule (76 FR 47308 through 47314) we announced that beginning in 2012, the hospice aggregate cap would be calculated using the patient-by-patient proportional methodology, within certain limits. Existing hospices had the

[2] Nelson, R., Should Medical Aid in Dying Be Part of Hospice Care? Medscape Nurses. February 26, 2020. *https://www.medscape.com/viewarticle/925769#vp_1.*

option of having their cap calculated through the original streamlined methodology, also within certain limits. As of FY 2012, new hospices have their cap determinations calculated using the patient-by-patient proportional methodology. If a hospice's total Medicare payments for the cap year exceed the hospice aggregate cap, then the hospice must repay the excess back to Medicare.

7. IMPACT Act of 2014

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113–185) became law on October 6, 2014. Section 3(a) of the IMPACT Act mandated that all Medicare certified hospices be surveyed every 3 years beginning April 6, 2015 and ending September 30, 2025. In addition, section 3(c) of the IMPACT Act requires medical review of hospice cases involving beneficiaries receiving more than 180 days of care in select hospices that show a preponderance of such patients; section 3(d) of the IMPACT Act contains a new provision mandating that the cap amount for accounting years that end after September 30, 2016, and before October 1, 2025 be updated by the hospice payment percentage update rather than using the consumer price index for urban consumers (CPI–U) for medical care expenditures.

8. FY 2015 Hospice Wage Index and Payment Rate Update Final Rule

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50452) finalized a requirement that the Notice of Election (NOE) be filed within 5 calendar days after the effective date of hospice election. If the NOE is filed beyond this 5-day period, hospice providers are liable for the services furnished during the days from the effective date of hospice election to the date of NOE filing (79 FR 50474). As with the NOE, the claims processing system must be notified of a beneficiary's discharge from hospice or hospice benefit revocation within 5 calendar days after the effective date of the discharge/revocation (unless the hospice has already filed a final claim) through the submission of a final claim or a Notice of Termination or Revocation (NOTR).

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50479) also finalized a requirement that the election form include the beneficiary's choice of attending physician and that the beneficiary provide the hospice with a signed document when he or she chooses to change attending physicians.

In addition, the FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50496) provided background, described eligibility criteria, identified survey respondents, and otherwise implemented the Hospice Experience of Care Survey for informal caregivers. Hospice providers were required to begin using this survey for hospice patients as of 2015.

Finally, the FY 2015 Hospice Wage Index and Rate Update final rule required providers to complete their aggregate cap determination not sooner than 3 months after the end of the cap year, and not later than 5 months after, and remit any overpayments. Those hospices that fail to submit their aggregate cap determinations on a timely basis will have their payments suspended until the determination is completed and received by the Medicare contractor (79 FR 50503).

9. FY 2016 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142), CMS finalized two different payment rates for RHC: a higher per diem base payment rate for the first 60 days of hospice care and a reduced per diem base payment rate for subsequent days of hospice care. CMS also finalized a service intensity add-on (SIA) payment payable for certain services during the last 7 days of the beneficiary's life. A service intensity add-on payment will be made for the social worker (SW) visits and nursing visits provided by a registered nurse (RN), when provided during routine home care in the last 7 days of life. The SIA payment is in addition to the routine home care rate. The SIA payment is provided for visits of a minimum of 15 minutes and a maximum of 4 hours per day (80 FR 47172).

In addition to the hospice payment reform changes discussed, the FY 2016 Hospice Wage Index and Rate Update final rule implemented changes mandated by the IMPACT Act, in which the cap amount for accounting years that end after September 30, 2016 and before October 1, 2025 would be updated by the hospice payment update percentage rather than using the CPI–U (80 FR 47186). In addition, we finalized a provision to align the cap accounting year for both the inpatient cap and the hospice aggregate cap with the FY for FY 2017 and thereafter. Finally, the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47144) clarified that hospices would have to report all diagnoses on the hospice claim as a part of the ongoing data collection efforts for possible future hospice payment refinements.

10. FY 2017 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52160), CMS finalized several new policies and requirements related to the HQRP. First, CMS codified the policy that if the National Quality Forum (NQF) made non-substantive changes to specifications for HQRP measures as part of the NQF's re-endorsement process, CMS would continue to utilize the measure in its new endorsed status, without going through new notice-and-comment rulemaking. CMS would continue to use rulemaking to adopt substantive updates made by the NQF to the endorsed measures adopted for the HQRP; determinations about what constitutes a substantive versus non-substantive change would be made on a measure-by-measure basis. Second, we finalized two new quality measures for the HQRP for the FY 2019 payment determination and subsequent years: (1) Hospice Visits when Death is Imminent Measure Pair; and (2) Hospice and Palliative Care Composite Process Measure-Comprehensive Assessment at Admission (81 FR 52173). The data collection mechanism for both of these measures is the Hospice Item Set (HIS), and the measures were effective April 1, 2017. Regarding the CAHPS® Hospice Survey, CMS finalized a policy that hospices that receive their CMS Certification Number (CCN) after January 1, 2017 for the FY 2019 Annual Payment Update (APU) and January 1, 2018 for the FY 2020 APU will be exempted from the Hospice CAHPS® requirements due to newness (81 FR 52182). The exemption is determined by CMS and is only for 1 year.

11. FY 2020 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38484), we finalized rebased payment rates for CHC and GIP and set those rates equal to their average estimated FY 2019 costs per day. We also rebased IRC per diem rates equal to the estimated FY 2019 average costs per day, with a reduction of 5 percent to the FY 2019 average cost per day to account for coinsurance. We finalized the FY 2020 proposal to reduce the RHC payment rates by 2.72 percent to offset the increases to CHC, IRC, and GIP payment rates to implement this policy in a budget-neutral manner in accordance with section 1814(i)(6) of the Act (84 FR 38496).

In addition, we finalized a policy to use the current year's pre-floor, pre-reclassified hospital inpatient wage index as the wage adjustment to the labor portion of the hospice rates. Finally, in the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38505), we finalized modifications to the hospice election statement content requirements at § 418.24(b), and added a requirement for hospices, upon request, to furnish an election statement addendum effective beginning in FY 2021. The addendum must list items, services, and drugs the hospice has determined to be unrelated to the terminal illness and related conditions, to increase coverage transparency for beneficiaries under a hospice election.

12. Consolidated Appropriations Act, 2021

Division CC, section 404 of the CAA 2021 amended section 1814(i)(2)(B) of the Act and extended the provision that currently mandates the hospice cap be updated by the hospice payment update percentage (hospital market basket update reduced by the productivity adjustment) rather than the CPI–U for accounting years that end after September 30, 2016 and before October 1, 2030. Prior to enactment of this provision, the hospice cap update was set to revert to the original methodology of updating the annual cap amount by the CPI–U beginning on October 1, 2025. Division CC, section 407(b) of CAA 2021 revised section 1814(i)(5)(A)(i) to increase the payment reduction for hospices who fail to meet hospice quality measure reporting requirements from 2 percentage points to 4 percentage points beginning with FY 2024.

13. FY 2022 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42532 through 42539), we finalized a policy to rebase and revise the labor shares for CHC, RHC, IRC and GIP using Medicare cost report (MCR) data for freestanding hospices (collected via CMS Form 1984–14, OMB NO. 0938–0758) for 2018. We established separate labor shares for CHC, RHC, IRC, and GIP based on the calculated compensation cost weights for each level of care from the 2018 MCR data. The revised labor shares were implemented in a budget neutral manner through the use of labor share standardization factors.

In the FY 2022 final rule, we removed the seven original Hospice Item Set (HIS) measures from the program because a more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available and already publicly reported. The Hospice Comprehensive Assessment Measure, NQF #3235, is one measure that is calculated and rolled up by completion of the seven individual measures. This measure helps to ensure all hospice patients receive a holistic comprehensive assessment. Also, in or after May 2022, we will start publicly reporting the two new claims-based measures. Specifically, this includes the: (1) Hospice Visits in the Last Days of Life (HVLDL) (which replaces the HIS Hospice Visits when Death is Imminent measure pair); and (2) Hospice Care Index (HCI) that includes 10 indicators that collectively represent different aspects of hospice care and aim to convey a comprehensive characterization of the quality of care furnished by a hospice throughout the hospice stay. Related to these changes, we finalized reporting eight quarters of claims data in order to display small providers. We finalized the public reporting of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey Star ratings on Care Compare to begin no sooner than FY 2022.

III. Analysis of and Responses to Public Comments

We received approximately 73 comments from stakeholders including national hospice associations, state associations, hospices, health systems, electronic health record vendors, and individuals. We reviewed each commenter's letter and grouped related comments. Some comments were identical. After associating like comments, we placed them in categories based on subject matter or based on the section(s) of the regulation affected. Summaries of the public comments received and our responses to those comments are provided in the appropriate sections in the preamble of this final rule.

IV. Provisions of the Final Rule

A. FY 2023 Hospice Wage Index and Rate Update

1. FY 2023 Hospice Wage Index

The hospice wage index is used to adjust payment rates for hospices under the Medicare program to reflect local differences in area wage levels, based on the location where services are furnished. The hospice wage index utilizes the wage adjustment factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act for hospital wage adjustments. Our regulations at § 418.306(c) require each labor market to be established using the most current hospital wage data available, including any changes made by the Office of Management and Budget (OMB) to the Metropolitan Statistical Areas (MSAs) definitions.

In general, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses. On March 6, 2020, OMB issued Bulletin No. 20–01, which provided updates to and superseded OMB Bulletin No. 18–04 that was issued on September 14, 2018. The attachments to OMB Bulletin No. 20–01 provided detailed information on the update to statistical areas since September 14, 2018, and were based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2017 and July 1, 2018. (For a copy of this bulletin, we refer readers to the following website: *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf.* In OMB Bulletin No. 20–01, OMB announced one new Micropolitan Statistical Area, one new component of an existing Combined Statistical Area (CSA), and changes to New England City and Town Area (NECTA) delineations. In the FY 2021 Hospice Wage Index final rule (85 FR 47070) we stated that if appropriate, we would propose any updates from OMB Bulletin No. 20–01 in future rulemaking. After reviewing OMB Bulletin No. 20–01, we determined that the changes in Bulletin 20–01 encompassed delineation changes that would not affect the Medicare wage index for FY 2022. Specifically, the updates consisted of changes to NECTA delineations and the redesignation of a single rural county into a newly created Micropolitan Statistical Area. The Medicare wage index does not utilize NECTA definitions, and, as most recently discussed in the FY 2021 Hospice Wage Index final rule (85 FR 47070), we include hospitals located in Micropolitan Statistical areas in each state's rural wage index.

In the FY 2020 Hospice Wage Index final rule (84 FR 38484), we finalized the proposal to use the current FY's hospital wage index data to calculate the hospice wage index values. In the FY 2021 Hospice Wage Index final rule (85 FR 47070), we adopted the revised OMB delineations with a 5-percent cap on wage index decreases, where the estimated reduction in a geographic area's wage index would be capped at 5-percent in FY 2021 and no cap would be applied to wage index decreases for

the second year (FY 2022). For FY 2023, the final hospice wage index will be based on the FY 2023 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2018 and before October 1, 2019 (FY 2019 cost report data). The final FY 2023 hospice wage index will not take into account any geographic reclassification of hospitals, including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The FY 2023 hospice wage index will include a 5-percent cap on wage index decreases, as discussed later in this section. The appropriate wage index value would be applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

In the FY 2006 Hospice Wage Index final rule (70 FR 45135), we adopted the policy that, for urban labor markets without a hospital from which hospital wage index data could be derived, all of the CBSAs within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. For FY 2023, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville-Fort Stewart, Georgia. The FY 2023 final wage index value for Hinesville-Fort Stewart, Georgia is 0.8628.

There exist some geographic areas where there were no hospitals, and thus, no hospital wage data on which to base the calculation of the hospice wage index. In the FY 2008 Hospice Wage Index final rule (72 FR 50217 through 50218), we implemented a methodology to update the hospice wage index for rural areas without hospital wage data. In cases where there was a rural area without rural hospital wage data, we use the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs, to represent a reasonable proxy for the rural area. The term ''contiguous'' means sharing a border (72 FR 50217). Currently, the only rural area without a hospital from which hospital wage data could be derived is Puerto Rico. However, for rural Puerto Rico, we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity of almost all of Puerto Rico's various urban areas to non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we would continue to use the most recent wage index previously available for that area. For FY 2023, we proposed to continue using the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047, subsequently adjusted by the hospice floor.

As described in the August 8, 1997 Hospice Wage Index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values are subject to application of the hospice floor to compute the hospice wage index used to determine payments to hospices. As previously discussed, the pre-floor, pre-reclassified hospital wage index values below 0.8 will be further adjusted by a 15 percent increase subject to a maximum wage index value of 0.8. For example, if County A has a pre-floor, pre-reclassified hospital wage index value of 0.3994, we would multiply 0.3994 by 1.15, which equals 0.4593. Since 0.4593 is not greater than 0.8, then County A's hospice wage index would be 0.4593. In another example, if County B has a pre-floor, pre-reclassified hospital wage index value of 0.7440, we would multiply 0.7440 by 1.15, which equals 0.8556. Because 0.8556 is greater than 0.8, County B's hospice wage index would be 0.8.

The final hospice wage index applicable for FY 2023 (October 1, 2022 through September 30, 2023) is available on the CMS website at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html.*

We received 8 comments on the proposed FY 2023 hospice wage index from various stakeholders including hospices and national industry associations. A summary of these comments and our responses to those comments are as follows:

Comment: A few commenters expressed concerns regarding the CBSA designation of Montgomery County, Maryland and its associated wage index value. These commenters stated that hospices in Montgomery County, Maryland are at a disadvantage because they are not included in the Washington-Arlington-Alexandria, DC-VA-MD-WV CBSA (CBSA 47894). Two commenters requested that CMS reconsider the Frederick-Gaithersburg-Rockville, Maryland metropolitan division to resolve the hospice payment inequity in Montgomery County. Another commenter recommended three possible solutions to resolve the wage index issue they believe exists in Montgomery County, Maryland. These recommended solutions include: CMS assigning the District of Columbia (DC) hospice wage index valuation to the Montgomery/Frederick County CBSA; CMS assigning the highest wage index valuation from among the MSAs' metropolitan divisions, also known as CBSAs, for the purpose of hospice Medicare reimbursement; CMS pursuing either option for a time limited period, such as 5 years, in order to evaluate the impact on Montgomery County hospices.

Response: We thank the commenters for these recommendations. However, we have used CBSAs for determining hospice payments since FY 2006, and continue to believe that the OMB's geographic area delineations represent a useful proxy for differentiating between labor markets and that the geographic area delineations are appropriate for use in determining Medicare hospice payments. CBSAs provide a uniform and consistent basis for determining statistical area delineations, based on long-standing statistical standards maintained by OMB. Further, OMB conducts periodic review of the standards to ensure their continued usefulness and relevance. Additionally, other provider types, such as Inpatient Prospective Payment System (IPPS) hospitals, home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and dialysis facilities, all use CBSAs to define their labor market areas. Therefore, we believe it is important to apply this method consistently among providers. Using the most current OMB delineations provides an accurate representation of geographic variation in wage levels; therefore, we do not believe it would be appropriate to allow hospices to be assigned a higher CBSA designation or to allow a 5-year limited increase in hospice wage index payments for hospices only in the Montgomery County Metropolitan Divisions. However, if Montgomery County is ever redesignated into CBSA 47894, we would propose this change in future rulemaking consistent with our longstanding approach of adopting OMB statistical area delineations outlined in the most recent OMB bulletins.

Comment: One commenter stated that the pre-floor, pre-reclassified hospital wage index is inadequate for adjusting hospice and home health costs, particularly in states that have the nation's highest labor costs. The commenter stated that these costs will never be adequately addressed if CMS continues to use the pre-floor, pre-reclassified hospital wage index to

adjust hospice and home health costs. Several commenters recommended more far-reaching revisions and reforms to the wage index methodology used under Medicare fee-for-service, such as instituting a policy that no hospice be paid below the rural floor for their state or considering a rural floor for hospices that exceed a 3 percent or greater gap between their urban versus average rural rate. Other commenters recommended that CMS allow hospices and other post-acute providers to utilize a reclassification board similar to hospitals. Another commenter suggested that CMS revisit MedPAC's 2007 proposal, which recommended that the Congress repeal the existing hospital wage index statute, including reclassifications and exceptions, and give the Secretary authority to establish new wage index systems.

Response: We appreciate the commenters' recommendations; however, these comments are outside the scope of the proposed rule. Any changes regarding the adjustment of the hospice payments to account for geographic wage differences, beyond the wage index proposals discussed in the FY 2023 Hospice Wage Index and Rate Update proposed rule, would have to go through notice and comment rulemaking. While CMS and other interested parties, such as MedPAC, have explored potential alternatives to the current CBSA-based labor market system, no consensus has been achieved regarding how best to implement a replacement system. We believe that in the absence of hospice specific wage data, using the pre-floor, pre-reclassified hospital wage data is appropriate and reasonable for hospice payments.

Additionally, the regulations that govern hospice payment do not provide a mechanism for allowing hospices to seek geographic reclassification or to utilize the rural floor provisions that exist for IPPS hospitals. The reclassification provision found in section 1886(d)(10) of the Act is specific to hospitals. Section 4410(a) of the Balanced Budget Act of 1997 (Pub. L. 105–33) provides that the area wage index applicable to any hospital that is located in an urban area of a state may not be less than the area wage index applicable to hospitals located in rural areas in that state. This rural floor provision is also specific to hospitals. Because the reclassification provision and the hospital rural floor applies only to hospitals, and not to hospices, we continue to believe the use of the pre-floor and pre-reclassified hospital wage index results is the most appropriate adjustment to the labor portion of the hospice payment rates. This position is longstanding and consistent with other Medicare payment systems (for example, SNF PPS, IRF PPS, and HH PPS). However, the hospice wage index does include the hospice floor which is applicable to all CBSAs, both rural and urban. The hospice floor adjusts pre-floor, pre-reclassified hospital wage index values below 0.8 by a 15 percent increase subject to a maximum wage index value of 0.8.

Final Decision: We are finalizing our proposal to use the FY 2023 pre-floor, pre-reclassified hospital wage index data as the basis for the FY 2023 hospice wage index. The wage index applicable for FY 2023 is available on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/Hospice/Hospice-Wage-Index.* The hospice wage index for FY 2023 is effective October 1, 2022 through September 30, 2023.

2. Permanent Cap on Wage Index Decreases

As discussed in this section, we have proposed and finalized temporary transition policies in the past to mitigate significant changes to payments due to changes to the hospice wage index. Specifically, in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142) we implemented a 50/50 blend for all geographic areas consisting of the wage index values using the then-current OMB area delineations and the wage index values using OMB's new area delineations based on OMB Bulletin No. 13–01. In the FY 2021 Hospice Wage Index final rule (85 FR 47070), we adopted the revised OMB delineations with a 5-percent cap on wage index decreases, where the estimated reduction in a geographic area's wage index would be capped at 5-percent in FY 2021 and no cap would be applied to wage index decreases for the second year (FY 2022). As explained, we believed the 5-percent cap would provide greater transparency and be administratively less complex than the prior methodology of applying a 50/50 blended wage index. We noted that this transition approach struck an appropriate balance by providing a transition period to mitigate the resulting short-term instability and negative impacts on providers and time for them to adjust to their new labor market area delineations and wage index values.

In the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42541), a few commenters stated that providers should be protected against substantial payment reductions due to dramatic reductions in wage index values from one year to the next. Because we did not propose to modify the transition policy that was finalized in the FY 2021 Hospice final rule, we did not extend the transition period for FY 2022. In the FY 2022 Hospice final rule, we stated that we continued to believe that applying the 5-percent cap transition policy in year one provided an adequate safeguard against any significant payment reductions associated with the adoption of the revised CBSA delineations in FY 2021, allowed for sufficient time to make operational changes for future FYs, and provided a reasonable balance between mitigating some short-term instability in hospice payments and improving the accuracy of the payment adjustment for differences in area wage levels. However, we acknowledged that certain changes to wage index policy may significantly affect Medicare payments. In addition, we reiterated that our policy principles with regard to the wage index include generally using the most current data and information available and providing that data and information, as well as any approaches to addressing any significant effects on Medicare payments resulting from these potential scenarios, in notice and comment rulemaking. With these policy principles in mind, we considered for the FY 2023 Hospice proposed rule how best to address the potential scenarios about which commenters raised concerns; that is, scenarios in which changes to wage index policy may significantly affect Medicare payments.

In the past, we have established transition policies of limited duration to phase in significant changes to labor market areas. In taking this approach in the past, we sought to mitigate short term instability and fluctuations that can negatively impact providers due to wage index changes. In accordance with the requirement of our regulations at § 418.306(c) each labor market is established using the most current hospital wage data available, including any changes made by the OMB to the Metropolitan Statistical Areas (MSAs) definitions. We have previously stated that, because the wage index is a relative measure of the value of labor in prescribed labor market areas, we believe it is important to implement new labor market area delineations with as minimal a transition as is reasonably possible. However, we recognize that changes to the wage index have the potential to create instability and significant negative impacts on certain providers even when labor market areas do not change. In addition, year-to-year fluctuations in an area's wage index can

occur due to external factors beyond a provider's control, such as the COVID–19 public health emergency (PHE), and for an individual provider, these fluctuations can be difficult to predict. We also recognize that predictability in Medicare payments is important to enable providers to budget and plan their operations.

In light of these considerations, for FY 2023 and subsequent years, we proposed to apply a permanent 5-percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. That is, we proposed that a geographic area's wage index for FY 2023 would not be less than 95 percent of its final wage index for FY 2022, regardless of whether the geographic area is part of an updated CBSA, and that for subsequent years, a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY. We further proposed that if a geographic area's prior FY wage index is calculated based on the 5-percent cap, then the following year's wage index would not be less than 95 percent of the geographic area's capped wage index in the prior FY. For example, if a geographic area's wage index for FY 2023 is calculated with the application of the 5-percent cap, then its wage index for FY 2024 would not be less than 95 percent of its capped wage index in FY 2023. Likewise, we proposed to make the corresponding regulations text changes at § 418.306(c) as follows: starting on October 1, 2022, CMS applies a cap on decreases to the hospice wage index such that the wage index applied to a geographic area is not less than 95 percent of the wage index applied to that geographic area in the prior FY. This 5-percent cap on negative wage index changes would be implemented in a budget neutral manner through the use of wage index standardization factors. Furthermore, the 5-percent cap would be applied after the application of the hospice wage index floor. Therefore, pre-floor, pre-reclassified hospital wage index values below 0.8 would be adjusted by the 15 percent increase, subject to a maximum wage index value of 0.8. If there is a 5-percent decrease from the previous FY's wage index value after the application of the hospice wage index floor, then the 5-percent cap on wage index decreases would also be applied. We stated that we believe that applying a 5-percent cap on all wage index decreases, from the prior year, would have a small overall impact on the labor market area wage index system. We estimate that applying a 5-percent cap on all wage index decreases, from the prior year, will have a very small effect on the wage index budget standardization factors for FY 2023. Because the wage index is a measure of the value of labor (wage and wage-related costs) in a prescribed labor market area relative to the national average, we anticipate that most providers will not experience year-to-year wage index declines greater than 5-percent in any given year. We believe that applying a 5-percent cap on all wage index decreases, from the prior year, would continue to maintain the accuracy of the overall labor market area wage index system.

In section III.A.4 of this final rule, we estimate the impact to payments for providers in FY 2023 based on this final policy. We also note that we would examine the effects of this policy on an ongoing basis in the future in order to assess its appropriateness.

We received 23 comments on the proposed permanent cap on wage index decreases. A summary of these comments and our responses to those comments are as follows:

Comment: The majority of commenters expressed support for the proposal to cap wage index decreases at 5 percent.

Response: We thank the commenters for their support of the proposed wage index cap policy.

Comment: MedPAC expressed support for the wage index cap proposal, but recommended that the 5-percent cap also extend to wage index increases of more than 5 percent, such that no geographic area would have its wage index value increase or decrease by more than 5 percent in any given year. In addition, MedPAC recommended that the implementation of the revised relative wage index values (where changes are limited to plus or minus 5 percent) should be done in a budget-neutral manner.

Response: We appreciate MedPAC's suggestion that the cap on wage index changes of more than 5 percent should also be applied to increases in the wage index. However, as we discussed in the proposed rule, one purpose of the proposed policy is to help mitigate the significant negative impacts of certain wage index changes. As we noted in the FY 2023 Hospice proposed rule (87 FR 19447), we believe applying a 5-percent cap on all wage index decreases would support increased predictability about hospice payments for providers, enabling them to more effectively budget and plan their operations. That is, we proposed to cap decreases because we believe that a provider would be able to more effectively budget and plan when there is predictability about its expected minimum level of hospice payments in the upcoming fiscal year. We did not propose to limit wage index increases because we do not believe such a policy would enable hospices to more effectively budget and plan their operations. Rather, we believe it would be more appropriate to allow providers that would experience an increase in their wage index value to receive the full benefit of their increased wage index value.

Comment: A few commenters recommended lowering the threshold percentage of the cap to percentages ranging from 2 percent to 4 percent. In general, these commenters believe that a more gradual approach to lowering the cap would better allow hospices to plan their operations. One commenter stated that lowering the threshold of the wage index cap would protect hospice providers who are already operating with negative operating margins and still experiencing multiple negative consequences due to the COVID pandemic, such has increased costs and loss of staff. Another commenter recommended that CMS finalize the permanent cap on hospice wage index decreases to 2 percent in a non-budget neutral way.

Response: We believe that the 5-percent cap on wage index decreases is an adequate safeguard against any significant payment reductions and that lowering the cap on wage index decreases below 5 percent is not appropriate. We also believe that 5 percent is a reasonable level for the cap because it would more effectively mitigate any significant decreases in a hospice's wage index for future FYs, while still balancing the importance of ensuring that area wage index values accurately reflect relative differences in area wage levels. Additionally, we believe that a 5-percent cap on wage index decreases in FY 2023 and beyond is sufficient and provides a degree of predictability in payment changes for providers; and it would not be appropriate to implement the cap policy in a non-budget neutral manner. Our longstanding policy is to apply the wage index standardization factors to hospice payments to eliminate the aggregate effect of wage index updates and revisions, such as updates in the underlying hospital wage data as well as other proposed wage index policies, resulting in any wage index changes being budget-neutral in the aggregate. In the FY 2023 hospice proposed rule (87 FR 19448), we stated that we believe that applying a 5-percent cap on all wage index decreases, from the prior year, would have a small overall impact

on the labor market area wage index system. We estimate that applying a 5-percent cap on all wage index decreases, from the prior year, will have a very small effect on the wage index budget standardization factors for FY 2023 and we expect the impact to the wage index budget neutrality factor in future years will continue to be minimal.

Comment: A few commenters requested a temporary transition policy for providers that saw decreases in their FY 2022 wage indexes. Several commenters recommended CMS adopt a transition policy that treats affected hospice providers' FY 2023 wage index as if a 5-percent cap had also been implemented for FY 2022, while other commenters requested that CMS retroactively apply the permanent wage index cap proposal to FY 2022 payments.

Response: We thank commenters for these recommendations. In FY 2021 rulemaking, CMS proposed and finalized the one-year transition policy for FY 2021 only. We have historically implemented 1-year transitions, as discussed in the FY 2006 (70 FR 45137) and FY 2016 (80 FR 47142) final rules, to address CBSA changes due to substantial updates to OMB delineations. Our policy principles with regard to the wage index are to use the most current data and information available. Therefore, we proposed that the FY 2023 Hospice wage index policy would be prospective to mitigate any significant decreases beginning in FY 2023, not retroactively.

As such, we did not calculate or propose the FY 2023 wage index as if the cap was in place for 2022. We note that we received comments on the FY 2022 proposed rule requesting an extension to the one-year transition policy for FY 2021; however, because we did not propose this policy, or the wage index standardization factors that we would have anticipated such a potential policy proposal to require in the FY 2023 proposed rule, we did not propose a policy that treats affected hospice providers' FY 2023 wage index as if a 5-percent cap had also been implemented for FY 2022, or include any data and information that warrant the use of a cap for FY 2022 data in order to calculate the FY 2023 wage index. While such a policy may benefit some providers, it would change the wage index standardization factors, and would impact the FY 2023 payment rates for all providers without allowing them the opportunity to comment.

Final Decision: CMS is finalizing for FY 2023 and subsequent years the application of a permanent 5-percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. That is, we are finalizing our policy that a geographic area's wage index for FY 2023 would not be less than 95 percent of its final wage index for FY 2022, regardless of whether the geographic area is part of an updated CBSA, and that for subsequent years, a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY. We are codifying the permanent cap on wage index decreases in regulation at § 418.306(c).

As previously discussed, we believe this methodology will maintain the hospice wage index as a relative measure of the value of labor in prescribed labor market areas, increase predictability of hospice payments for providers, and mitigate instability and significant negative impacts to providers resulting from significant changes to the wage index. In section X of this final rule, we estimate the impact to payments for providers in FY 2023 based on this policy. We also note that we will examine the effects of this policy on an ongoing basis in the future in order to assess its appropriateness.

3. FY 2023 Hospice Payment Update Percentage

Section 4441(a) of the BBA (Pub. L. 105–33) amended section 1814(i)(1)(C)(ii)(VI) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the inpatient hospital market basket percentage increase set out under section 1886(b)(3)(B)(iii) of the Act, minus 1 percentage point. Payment rates for FYs since 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs must be the inpatient market basket percentage increase for that FY. In the FY 2022 IPPS final rule CMS finalized the proposal to rebase and revise the IPPS market baskets to reflect a 2018 base year. We refer readers to the FY 2022 IPPS final rule for further information (86 FR 45194 through 45208).

Section 3401(g) of the Affordable Care Act mandated that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage would be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the ''productivity adjustment''). The United States Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the United States economy. We note that previously the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) was published by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021 release of productivity data, BLS replaced the term ''multifactor productivity'' with ''total factor productivity'' (TFP). BLS noted that this is a change in terminology only and will not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is now published by BLS as ''private nonfarm business total factor productivity.'' However, as mentioned, the data and methods are unchanged. We refer readers to *http://www.bls.gov* for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.* In addition, in the FY 2022 IPPS final rule (86 FR 45214), we noted that beginning with FY 2022, CMS changed the name of this adjustment to refer to it as the ''productivity adjustment'' rather than the ''MFP adjustment''.

In the FY 2023 Hospice Wage Index and Payment Rate Update proposed rule (87 FR 19448), we proposed a hospice market basket increase of 3.1 percent for FY 2023 using the most current estimate of the inpatient hospital market basket (based on IHS Global Inc.'s fourth quarter 2021 forecast with historical data through the third quarter 2021). Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the proposed inpatient hospital market basket update for FY 2023 of 3.1 percent was reduced by a productivity adjustment as mandated by the Affordable Care Act (estimated in the proposed rule to be 0.4 percentage point for FY 2023). Therefore, the proposed hospice payment update percentage for FY 2023 was 2.7 percent.

We stated that if more recent data became available after the publication of the proposed rule and before the publication of the final rule (for example, more recent estimates of the

inpatient hospital market basket update and productivity adjustment), we would use such data, if appropriate, to determine the hospice payment update percentage for FY 2023 in the final rule. For this final rule, based on IHS Global Inc.'s (IGI) second quarter 2022 forecast with historical data through the first quarter 2022 of the inpatient hospital market basket update, the market basket percentage increase for FY 2023 is 4.1 percent. The productivity adjustment for FY 2023, based on IGI's second quarter 2022 forecast, is 0.3 percent. Therefore, the hospice payment update percentage for FY 2023, based on more recent data, is 3.8 percent.

We continue to believe it is appropriate to routinely update the hospice payment system so that it reflects the best available data about differences in patient resource use and costs among hospices as required by the statute. Therefore, we proposed to: (1) update hospice payments using the methodology outlined and apply the 2018-based IPPS market basket update for FY 2023 of 4.1 percent, reduced by the statutorily required productivity adjustment of 0.3 percentage point along with the wage index budget neutrality adjustment to update the payment rates; and (2) use the FY 2023 hospice wage index which uses the FY 2023 pre-floor, pre-reclassified IPPS hospital wage index as its basis.

In the FY 2022 Hospice Wage Index final rule (86 FR 42532 through 42539), we rebased and revised the labor shares for RHC, CHC, GIP and IRC using MCR data for freestanding hospices (CMS Form 1984–14, OMB Control Number 0938–0758) from 2018. The current labor portion of the payment rates are: for RHC, 66.0 percent; for CHC, 75.2 percent; for GIP, 63.5 percent; and for IRC, 61.0 percent. The non-labor portion is equal to 100 percent minus the labor portion for each level of care. The non-labor portion of the payment rates are as follows: for RHC, 34.0 percent; for CHC, 24.8 percent; for GIP, 36.5 percent; and for IRC, 39.0 percent.

We received 28 comments on the proposed hospice update percentage of 2.7 percent. A summary of the comments and our responses to those comments are as follows:

Comment: One commenter expressed support for the 2.7 percent payment update and the 2-percentage point reduction for hospices that do not provide quality data.

Response: We thank the commenter for their support of the hospice payment update percentage.

Comment: MedPAC stated that while the commission recognizes that CMS is required by statute to propose an increase to the FY 2023 base rates by 2.7 percent, they recommend no update to the FY 2022 payment rates for FY 2023 (that is, hold the payment rates for FY 2023 at the FY 2022 levels).

Response: We thank the commission for their recommendation; however, we are statutorily required to update the payment rates for FY 2023 and do not have the authority to hold the payment rates to FY 2022 levels. Section 1814(i)(1)(C)(iii) of the Act requires the Secretary, for years subsequent to the first FY in which payment revisions described in paragraph (6)(D) are implemented, to update the payment rates by the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) of the Act for the FY; section 1814(i)(1)(C)(iv)(I) of the Act requires that subsequent to such increase, the payment rates be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

Comment: Many commenters expressed concerns about the proposed 2.7 percent payment rate update, especially when the 2 percent sequestration resumes in July 2022. Commenters stated hospice providers have incurred increased costs due to inflation and a health care workforce shortage, which is driving up the cost to hire and retain qualified staff. Several commenters stated hospices have also continued to incur costs to address the COVID–19 PHE, including for personal protective equipment and other infection control efforts. Several commenters noted the increase in gas prices and its impact on hospices, given the preponderance of home-based care delivery.

Several commenters noted that CMS stated that if more recent data became available after the publication of the proposed rule and before the publication of the final rule, it would consider such data to determine the hospice payment update percentage for FY 2023 in the final rule. They encouraged CMS to review the data carefully and exercise its flexibilities to more accurately determine adjustments to the hospice payment rates to account for inflation, ensuring adequate reimbursement.

Other commenters encouraged CMS to finalize a payment rate increase reflective of the current cost of care recommending that CMS pursue all possible administrative options available and provide a higher payment update for FY 2023. One commenter stated that to the extent CMS is restricted by statutory formulas for updating hospice payments, they recommend CMS work with the Congress to effectuate a higher, more sustainable hospice payment update percentage for FY 2023. Several commenters stated that if CMS is considering other alternatives to the hospital rate update that would take into account costs and challenges due to the COVID–19 PHE and inflation, then CMS should consider applying these same updates to the hospice rates. Commenters also requested CMS examine trends relative to IHS Global Inc.'s forecasts to determine whether more recently available data used for the final FY 2023 rule would result in a higher market basket update and determine whether additional updates could be made during the course of FY 2023 to provide additional support to hospice and other providers.

Response: Section 1814(i)(1)(C) of the Act, requires hospice payment rates be updated by the inpatient hospital market basket update and reduced by a productivity adjustment as mandated by the Affordable Care Act.

As described in the FY 2022 IPPS final rule (86 FR 45194 through 45214), the IPPS market basket is a fixed-weight, Laspeyres-type index that measures price changes over time of the mix of goods and services that hospitals purchase (hospital inputs) to furnish inpatient care. It would not reflect increases in costs associated with changes in the volume or intensity of input goods and services. As such, the IPPS market basket update would reflect the prospective price pressures described by the commenters as increasing during a high inflation period (such as faster wage growth or higher energy prices), but would not reflect other factors that might increase the level of costs, such as the quantity of labor used.

We agree with the commenters that recent higher inflationary trends have impacted the outlook for price growth over the next several quarters. At the time of the FY 2023 hospice proposed rule, based on IHS Global Inc. fourth quarter 2021 forecast with historical data through third quarter 2021, IHS Global Inc. forecasted the 2018-based IPPS market basket update of 3.1 percent for FY 2023 reflecting forecasted compensation price growth of 3.8 percent (by comparison, compensation price growth in the IPPS market basket averaged 2.1 percent over the 2012–2021 time period). In the FY 2023 Hospice proposed rule, we proposed that if more recent data became available, we would use such data, if appropriate, to derive the final FY 2023 hospice payment update for the final rule. For this final rule, we now have an updated forecast of the price proxies

underlying the market basket that incorporates more recent historical data and reflects a revised outlook regarding the United States economy and expected price inflation for FY 2023 for IPPS hospitals. Based on the IHS Global Inc. second quarter 2022 forecast with historical data through first quarter 2022, we are projecting a FY 2023 IPPS market basket update of 4.1 percent (reflecting forecasted compensation price growth of 4.8 percent) and productivity adjustment of 0.3 percentage point. Therefore, for FY 2023 a final hospice payment update of 3.8 percent (4.1 percent less 0.3 percentage point) will be applicable, compared to 2.7 percent as proposed. We note that the final FY 2023 IPPS market basket growth rate of 4.1 percent would be the highest market basket update implemented in an IPPS final rule going back to FY 1998.

Comment: A few commenters requested that CMS consider updating the base year for the hospital IPPS market basket from the current base year of 2018 to a more current base year. The commenter stated that this update will more accurately reflect the cost structure of hospital IPPS during the pandemic for inflationary adjustments to be applied against within the hospice wage index formula. One commenter noted that while they recognize that more recent final data may not yet be available, it should be clear that providers' cost structures have changed since 2018, including changes in operations that have been required as a result of the COVID–19 PHE.

Response: The CMS market baskets are fixed-weight, Laspeyres-type indexes in that they measure ''pure'' price changes only. Any changes in the quantity or mix of goods and services (that is, intensity) purchased over time are not measured. Changes in quantity or mix of goods and services do eventually get incorporated into the market basket cost weights when it is rebased. Therefore, we rebase the market baskets periodically so that the cost weights reflect more recent purchases of goods and services used by providers to furnish medical care. The IPPS market basket was last rebased in the FY 2022 IPPS final rule using 2018 Medicare cost reports (86 FR 45194 through 45207), the most recent year of complete data available at the time of the rebasing. We did not propose to rebase the IPPS market basket in the FY 2023 IPPS proposed rule. However, we did review the most recent Medicare cost report (MCR) data available for IPPS hospitals submitted as of March 2022, which includes data for 2019 through 2020. The MCR data for 2019 showed little change in the reported cost weights and MCR data for 2020 showed a slight decrease in the compensation cost weight (roughly 1 percentage point) relative to the 2018-based IPPS market basket cost weight. Data through 2021 are incomplete at this time. Based on this preliminary analysis, the impact on the cost weights through 2020 are minimal and it is unclear whether these trends (particularly the compensation cost weight) through 2020 are reflective of sustained shifts in the cost structure for hospitals or whether they were temporary as a result of the COVID–19 PHE. Therefore, we continue to believe it is premature at this time to use more recent MCR data to derive a rebased and revised IPPS market basket. We will continue to monitor these data and any changes to the IPPS market basket will be proposed in future rulemaking.

Final Decision: We are finalizing the hospice payment update percentage of 3.8 percent for FY 2023. Based on IHS Global, Inc.'s more recent forecast of the inpatient hospital market basket update and the productivity adjustment, the hospice payment update percentage for FY 2023 will be 3.8 percent for hospices that submit the required quality data and 1.8 percent (FY 2023 hospice payment update of 3.8 percent minus 2 percentage points) for hospices that do not submit the required data.

4. FY 2023 Hospice Payment Rates

There are four payment categories that are distinguished by the location and intensity of the hospice services provided. The base payments are adjusted for geographic differences in wages by multiplying the labor share, which varies by category, of each base rate by the applicable hospice wage index. A hospice is paid the RHC rate for each day the beneficiary is enrolled in hospice, unless the hospice provides CHC, IRC, or GIP. CHC is provided during a period of patient crisis to maintain the patient at home; IRC is short-term care to allow the usual caregiver to rest and be relieved from caregiving; and GIP is to treat symptoms that cannot be managed in another setting.

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47172), we implemented two different RHC payment rates: (1) RHC rate for the first 60 days; and (2) RHC rate for days 61 and beyond. In addition, in that final rule, we implemented an SIA payment for RHC when direct patient care is provided by an RN or social worker during the last 7 days of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided (up to 4 hours total) that occurred on the day of service, if certain criteria are met. In order to maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, the new RHC rates were adjusted by a service intensity add-on budget neutrality factor (SBNF). The SBNF is used to reduce the overall RHC rate in order to ensure that SIA payments are budget-neutral. At the beginning of every FY, SIA utilization is compared to the prior year in order calculate a budget neutrality adjustment.

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52156), we initiated a policy of applying a wage index standardization factor to hospice payments to eliminate the aggregate effect of annual variations in hospital wage data. Typically, the wage index standardization factor is calculated using the most recent, complete hospice claims data available. However, due to the COVID–19 PHE, in the FY 2022 Hospice Wage Index and Payment Rate Update proposed rule we looked at using hospice claims data before the declaration of the COVID–19 PHE (FY 2019) to determine if there were significant differences between utilizing 2019 and 2020 claims data. The difference between using FY 2019 and FY 2020 hospice claims data was minimal. Therefore, in the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42543), we stated that we would continue our practice of using the most recent, complete hospice claims data available. For FY 2023 hospice rate setting, we saw minimal differences in using the updated data; therefore, we are continuing our longstanding policy of using the most recent data available. Specifically, we are using FY 2021 claims data with the FY 2023 payment rate updates. In order to calculate the wage index standardization factor, we simulate total payments using FY 2021 hospice utilization claims data with the FY 2022 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, without the 5-percent cap on wage index decreases) and FY 2022 payment rates and compare it to our simulation of total payments using the FY 2023 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, with the 5-percent cap on wage index decreases) and FY 2022 payment rates. By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2022 wage index and payment rates for each level

of care by the FY 2023 wage index and FY 2022 payment rates, we obtain a wage index standardization factor for each level of care. The wage index standardization factors for each level of care are shown in the Tables 1 and 2.

The FY 2023 RHC rates are shown in Table 1. The FY 2023 payment rates for CHC, IRC, and GIP are shown in Table 2.

TABLE 1: FY 2023 Hospice RHC Payment Rates

Code	Description	FY 2022 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2023 Hospice Payment Update	FY 2023 Payment Rates
651	**Routine Home Care (days 1-60)**	$203.40	1.0003	1.0007	1.038	$211.34
651	**Routine Home Care (days 61+)**	$160.74	1.0003	1.0006	1.038	$167.00

TABLE 2: FY 2023 Hospice CHC, IRC, and GIP Payment Rates

Code	Description	FY 2022 Payment Rates	Wage Index Standardization Factor	FY 2023 Hospice Payment Update	FY 2023 Payment Rates
652	**Continuous Home Care Full Rate = 24 hours of care.**	$1,462.52	1.0026	1.038	$1,522.04
655	**Inpatient Respite Care**	$473.75	1.0007	1.038	$492.10
656	**General Inpatient Care**	$1,068.28	1.0017	1.038	$1,110.76

Sections 1814(i)(5)(A) through (C) of the Act require that hospices submit quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index and Rate Update final rule (76 FR 47320 through 47324), we implemented a HQRP as required by those sections. Hospices were required to begin collecting quality data in October 2012 and submit those quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. The FY 2023 rates for hospices that do not submit the required quality data would be updated by the FY 2023 hospice payment update percentage of 3.8 percent minus 2 percentage points. These rates are shown in Tables 3 and 4.

TABLE 3: FY 2023 Hospice RHC Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2022 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2023 Hospice Payment Update of 3.8% minus 2 percentage points = +1.8%	FY 2023 Payment Rates
651	Routine Home Care (days 1-60)	$203.40	1.0003	1.0007	1.018	$207.27
651	Routine Home Care (days 61+)	$160.74	1.0003	1.0006	1.018	$163.78

TABLE 4: FY 2023 Hospice CHC, IRC, and GIP Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2022 Payment Rates	Wage Index Standardization Factor	FY 2023 Hospice Payment Update of 3.8% minus 2 percentage points = +1.8%	FY 2023 Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care.	$1,462.52	1.0026	1.018	$1,492.72
655	Inpatient Respite Care	$473.75	1.0007	1.018	$482.62
656	General Inpatient Care	$1,068.28	1.0017	1.018	$1,089.36

Final Decision: We are finalizing the FY 2023 payment rates in accordance with statutorily mandated requirements.

5. Hospice Cap Amount for FY 2023

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47183), we implemented changes mandated by the IMPACT Act of 2014 (Pub. L. 113–185). Specifically, we stated that for accounting years that end after September 30, 2016 and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the CPI–U. Division CC, section 404 of the CAA 2021 extended the accounting years impacted by the adjustment made to the hospice cap calculation until 2030. In the FY 2022 Hospice Wage Index final rule (86 FR 42539), we finalized conforming regulations text changes at § 418.309 to reflect the provisions of the CAA 2021. Therefore, for accounting years that end after September 30, 2016 and before October 1, 2030, the hospice cap amount is updated by the hospice payment update percentage rather than using the CPI–U.

The hospice cap amount for the FY 2023 cap year is $32,486.92, which is equal to the FY 2022 cap amount ($31,297.61) updated by the FY 2023 hospice payment update percentage of 3.8 percent.

We received few comments regarding the hospice cap amount. A summary of these comments and our responses to those comments are as follows:

Comment: MedPAC recommended that the hospice aggregate cap be wage adjusted and reduced by 20 percent. Another commenter recommended several refinements to the cap including: wage adjusting the cap to address wage variation in a budget neutral manner, phasing in the adjustment over multiple years to minimize the potential impact on access to care and to allow the most negatively impacted areas of the country to adjust; and limiting variation in the wage index applicable to the cap (creating a ''floor''

and a ''ceiling'') to protect hospice providers from the significant swings that can accompany wage index changes from year to year, ensuring the cap value remains more consistent. One commenter stated that they would support a cap structure that aligns with hospices taking risk, but that also considers high inflationary factors. This commenter believes that CMS should align payment to account for these factors.

Response: We thank the commenters for their recommendations to improve the hospice cap; however, we are required by law to update the hospice cap amount from the preceding year by the hospice payment update percentage, in accordance with section 1814(i)(2)(B)(ii) of the Act. Therefore, we do not have the statutory authority to reduce the aggregate cap amount nor the statutory authority to wage-adjust the cap.

Final Decision: We are finalizing the update to the hospice cap amount for FY 2023 in accordance with statutorily mandated requirements.

B. Updates to the Hospice Quality Reporting Program (HQRP)

1. Background and Statutory Authority

The HQRP specifies reporting requirements for the Hospice Item Set (HIS), administrative data, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey. Section 1814(i)(5) of the Act requires the Secretary to establish and maintain a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA 2021 (Pub. L. 116–260) to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. This policy will apply beginning with FY 2024 annual payment update (APU) that is based on CY 2022 quality data. Specifically, the Act requires that, beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and beginning with the FY 2024 APU and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. Since this payment penalty increase to 4 percent is statutorily required and self-implementing, we cannot address comments on this topic.

Depending on the amount of the annual update for a particular year, a reduction of 2 percentage points through FY 2023 or 4 percentage points beginning in FY 2024 could result in the annual market basket update being less than zero percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. A reduction of 2 percentage points through FY 2023 or 4 percentage points beginning in FY 2024 based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the specified year. Typically, about 18 percent of Medicare-certified hospices are found non-compliant with the HQRP reporting requirements and subject to the APU payment reduction for a given fiscal year.

In the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), we finalized two new measures using claims data: (1) Hospice Visits in the Last Days of Life (HVLDL); and (2) Hospice Care Index (HCI). We also finalized a policy that claims-based measures will use 8 quarters of data in order to report on more hospices. In addition, we removed the seven Hospice Item Set (HIS) Process Measures from the program as individual measures and public reporting because the HIS Comprehensive Assessment Measure (NQF #3235) is sufficient for measuring care at admission without the seven individual process measures. For a detailed discussion of the historical use for measure selection and removal for the HQRP quality measures, we refer readers to the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142) and the FY 2019 Hospice Wage Index and Rate Update final rule (83 FR 38622). In the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42553), we finalized § 418.312(b)(2), which requires hospices to provide administrative data, including claims-based measures, as part of the HQRP requirements for § 418.306(b). In that same final rule, we provided CAHPS Hospice Survey updates. We finalized temporary changes to our public reporting policies based on the March 27, 2020 memorandum [3] and provided another tip sheet, referred to as the *Second Edition HQRP Public Reporting Tip Sheet* on the *HQRP Requirements and Best Practices web page.*

As finalized in the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), the inaugural display of the two new claims-based quality measures (QMs), the Hospice Visits in Last Days of Life (HVLDL) and the Hospice Care Index (HCI) will be available on the Care Compare/Provider Data Catalogue (PDC) web pages. In the FY 2023 Hospice proposed rule, we did not propose any new quality measures. However, we provide updates on already-adopted measures. Table 5 shows all quality measures finalized in the FY 2022 Hospice Wage Index and Payment Rate Update final rule and in effect for the FY 2023 HQRP.

[3] Exceptions and Extensions for Quality Reporting Requirements for Acute Care Hospitals, PPS-Exempt Cancer Hospitals, Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, Ambulatory Surgical Centers, Renal Dialysis Facilities, and MIPS Eligible Clinicians Affected by COVID–19. Available at: *https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.*

TABLE 5: Quality Measures finalized in the FY 2022 Hospice Wage Index Final Rule and in Effect for FY 2023 for the Hospice Quality Reporting Program

Hospice Quality Reporting Program	
NQF#	**Hospice Item Set**
3235	Hospice and Palliative Care Composite Process Measure—HIS-Comprehensive Assessment Measure at Admission includes: 1. Patients Treated with an Opioid who are Given a Bowel Regimen (NQF #1617) 2. Pain Screening 3. Pain Assessment 4. Dyspnea Treatment 5. Dyspnea Screening 6. Treatment Preferences 7. Beliefs/Values Addressed (if desired by the patient)
Administrative Data, including Claims-based Measures	
Pending NQF endorsement	Hospice Visits in Last Days of Life (HVLDL)
Pending NQF endorsement	Hospice Care Index (HCI) 1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided 2. Gaps in Skilled Nursing Visits 3. Early Live Discharges 4. Late Live Discharges 5. Burdensome Transitions (Type 1) – Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission 6. Burdensome Transitions (Type 2) – Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital 7. Per-beneficiary Medicare Spending 8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day 9. Skilled Nursing Minutes on Weekends 10. Visits Near Death
CAHPS Hospice Survey	
2651	CAHPS Hospice Survey 1. Communication with Family 2. Getting timely help 3. Treating patient with respect 4. Emotional and spiritual support 5. Help for pain and symptoms 6. Training family to care for the patient 7. Rating of this hospice 8. Willing to recommend this hospice

2. Hospice Outcomes & Patient Evaluation (HOPE) Update

As finalized in the FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule (84 FR 38484), we are developing a hospice patient assessment instrument identified as HOPE. HOPE would contribute to the patient's plan of care through patient assessments ongoing throughout the hospice stay. HOPE is intended to support the hospice conditions of participation (CoPs), including hospices' quality assessment and performance improvement (QAPI) programs and provide quality data to calculate outcome and other types of quality measures. Our primary objectives for HOPE are to provide quality data for the HQRP requirements through standardized data collection; support survey and certification processes; and provide additional clinical data that could inform future payment refinements.

HOPE would include key items from the HIS and demographics like gender and race. Some HIS items would be modified for inclusion in HOPE to increase specificity. This approach to include key demographic information reflects stakeholder feedback discussed in the FYs 2017 and 2018 Hospice Wage Index and Payment Rate Update final rules (81 FR 52171 and 82 FR 36669, respectively).

HOPE is multidisciplinary: the assessment instrument would be completed by nursing, social work, and spiritual care staff. We are undergoing testing with three distinct disciplinary assessments in beta field testing described in this section. We stated in the FY 2022 Hospice Wage Index and

Payment Update final rule (86 FR 42528) that while the standardized patient assessment data elements for certain post-acute care providers required under the IMPACT Act of 2014 are not applicable to hospices, it would be reasonable to include some of those standardized elements that appropriately and feasibly apply to hospice to the extent permitted by our statutory authority. Some patients may move through the healthcare system to hospice. Therefore, considering tracking key demographic and social risk factor items that apply to hospice could support our goals for continuity of care, overall patient care and well-being, interoperability of electronic health information, and health equity that is also discussed in this rule.

The draft of HOPE has undergone cognitive, pilot, and alpha testing, and is undergoing national beta field testing to establish reliability, validity, and feasibility of the assessment instrument. The purpose of the alpha test was to establish preliminary reliability and validity of the draft assessment items, and feasibility of implementing future requirements for hospices to utilize the HOPE assessment. Specifically, the objectives were to:

- Establish inter-rater reliability (IRR) of the assessment items.
- Demonstrate validity of the assessment items.
- Demonstrate feasibility of completing the assessment and time points during the hospice stay for data collection.

HOPE alpha testing was completed at the end of January 2021. Based on the quantitative data analyses and feedback from assessors in alpha testing, the items generally support the feasibility of collecting the data items. Alpha testing also showed that HOPE exhibited acceptable inter-rater reliability ranging from moderate to very good with few exceptions and demonstrated evidence of convergent validity. We used findings of the alpha test to inform decisions about the next draft of the HOPE assessment, which are being tested in the national beta test that began in late fall 2021 and will continue through 2022.

National beta testing allows us to obtain input from participating hospice teams about the assessment instrument and field testing to refine and support the final draft items and assessment time points for HOPE. It also allows us to estimate the time to complete the HOPE data items. We anticipate proposing HOPE in future rulemaking after testing and analyses are complete.

We continue HOPE development in accordance with the Blueprint for the CMS Measures Management System. HOPE development is grounded in information gathering activities to identify and refine hospice assessment domains and candidate assessment items. We appreciate the industry's and national associations' engagement in providing input through information sharing activities, including listening sessions, expert interviews, key stakeholder interviews, and focus groups to support HOPE development. As CMS proceeds with field testing HOPE, we will continue to engage with stakeholders through sub-regulatory channels. In particular, we will continue to host HQRP Forums to allow hospices and other interested parties to engage with us on the latest updates and ask questions on the development of HOPE and related quality measures. We also have a dedicated email account, *HospiceAssessment@cms.hhs.gov,* for comments about HOPE.

We will use field test results to create a final version of HOPE to propose in future rulemaking for national implementation. We will continue to engage all stakeholders throughout this process that includes a variety of sub-regulatory channels and regular HQRP communication strategies, such as Open Door Forums (ODF), Medicare Learning Network (MLN), *CMS.gov* website announcements, listserv messaging, and other ad hoc publicly announced opportunities. We appreciate the support for HOPE and reiterate our commitment to providing updates and engaging stakeholders through sub-regulatory means. HOPE updates can be found at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE* and engagement opportunities, including those regarding HOPE are at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.*

We received many comments related to HQRP. A summary of these comments and our responses to those comments as it relates to the HOPE update are as follows:

Comment: Commenters were generally supportive of HOPE and ongoing beta testing. Many commenters asked CMS to release additional information on HOPE, including reports and data, ahead of the official proposal to allow time for education, programming, and implementation of HOPE. Specifically, commenters asked for information regarding the timeline for HOPE implementation. There were numerous suggestions that HOPE could include health equity and social determinants of health (SDOH) data points, including those to support a structural health equity measure and assist hospices in assessing their own progress on health equity goals. One comment suggested HOPE as an opportunity to collect uniform self-reported data to support a future health equity structural measure.

A few comments raised concerns about the potential additional regulatory burden of HOPE, such as duplicative documentation. Another comment suggested HOPE leverage certified health IT capabilities to reduce administrative burden. Some comments noted concerns about conducting beta testing during the COVID–19 pandemic, stating that staffing concerns have exacerbated the administrative burden of HOPE beta testing. There was one comment suggesting the inclusion of occupational therapy practitioners among the providers who can complete HOPE assessments.

Response: We appreciate all stakeholders' input regarding HOPE development, and will take these comments into consideration for future rulemaking. We are committed to developing and implementing HOPE with a minimum burden to stakeholders. Additional information about HOPE will be presented to the public via sub-regulatory means, such as ODFs, Hospice Quality Reporting Program Forums, our HQRP web page, and other appropriate communications. We will propose HOPE in future rulemaking.

3. Update on Future Quality Measure (QM) Development

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484), we provided updates related to CMS's process for identifying high priority areas of quality measurement and improvement and for developing quality measures that address those priorities. Information on the current HQRP quality measures can be found at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.* In this final rule, we provide updates for hospice quality measure concepts based on future use of HOPE and administrative data. In section III.B.6, we summarize the public comments from hospices on the Request for Information (RFI) related to their health equity initiatives and a structural composite measure concept to inform future measure development.

To support new measure development, our contractor convened two technical expert panel (TEP)

meetings in 2021. The TEP considered HOPE-based process measures that may be proposed with HOPE in future rulemaking. The TEP meetings in 2021 included HOPE-based process measures intended to: (1) evaluate the rate at which hospices' use specific processes of care; (2) assist in reducing variation in care delivery; and (3) determine hospices' compliance with practices that are expected to improve outcomes. The TEP also considered potential areas for future quality measure development. We refer readers to the ''2021 Technical Expert Panel Meetings: Hospice Quality Reporting Program Summary Report'' available at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities*.

As stated in the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42528), We continue to consider developing hybrid quality measures that could be calculated from multiple data sources: for example, claims, assessments (HOPE), or other data sources. Hybrid quality measures allow for a more comprehensive set of information about care processes and outcomes than can be calculated using claims data alone. As described in the ''2021 Technical Expert Panel Meetings: Hospice Quality Reporting Program Summary Report,'' the TEP discussed hybrid concepts such as hospitalizations during a hospice election and patterns of live discharge using claims data and HOPE data elements.

We received several comments regarding the update on future QM development. A summary of these comments and our responses to those comments are as follows:

Comment: Several commenters suggested CMS develop measures to monitor hospice telehealth services and to add telehealth to claims. Some commenters indicated that existing measures, such as the claims-based HVLDL should be modified to recognize telehealth.

Other commenters suggested that CMS develop or revise quality measures to better reflect how hospices meet patient care goals. These suggestions included new quality measures for advance care planning and patient-reported measures related to how much patients felt understood and whether patients received the pain help they wanted. Related to these care goals and for future quality measure consideration, commenters seek to recognize visits by the full interdisciplinary care team, add spiritual care to claims, and consider occupational therapy and/or include it in the NQF #3235, the HIS Comprehensive Assessment Measure.

Commenters also recommended changes to the existing HVLDL measure, such as revising the specifications to recognize more hospice disciplines, including telehealth visits, or changing the timeframe the measure reflects.

In addition, commenters suggested changes to the existing HCI measure, such as differentiating when patients refuse provider visits from when providers fail to offer visits, or changing the timeframe of the ''Visits Near Death'' indicator.

Commenters made suggestions regarding how future QMs should be designed. These suggestions included considerations for hybrid measures and requests for more clarity on how CMS determines if proposed measures address quality of care. Other commenters emphasized the importance of minimizing the administrative burden of new quality measure implementation and data collection.

Response: We appreciate the input regarding quality measure development, and will take these comments into consideration for future QM development initiatives. We are committed to the Meaningful Measures Initiative (*https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy*) and Measures Management System Blueprint (*https://mmshub.cms.gov/blueprint-measure-lifecycle-overview*) that informs and guides quality measure development priorities and processes.

4. Updates to the CAHPS Hospice Survey Participation Requirements for the FY 2023 APU and Subsequent Years

a. Background and Description of the CAHPS Hospice Survey

The CAHPS Hospice Survey is a component of the CMS HQRP, which is used to collect data on the experiences of hospice patients and the primary caregivers listed in their hospice records. We refer readers who may want more information about the development of the survey, originally called the Hospice Experience of Care Survey to see our discussions of the survey in the FY 2015 Hospice Wage Index final rule (79 FR 50452, 50491) and the FY 2014 Hospice Wage Index final rule (78 FR 48234, 48261).).

b. Overview of the ''CAHPS Hospice Survey Measures''

The CAHPS Hospice Survey measures were re-endorsed by NQF on November 20, 2020. The re-endorsement can be found on the NQF website at: *https://www.qualityforum.org/Measures_Reports_Tools.aspx.* The survey received its initial NQF endorsement on October 26, 2016 (NQF #2651). We adopted 8 survey-based measures for the CY 2018 data collection period and for subsequent years. These eight measures are publicly reported on a designated CMS website, Care Compare, *https://www.medicare.gov/care-compare/.*

c. CAHPS Hospice Survey Mode Experiment

CMS recently conducted a mode experiment with the goal of testing the effects of adding a web-based mode to the CAHPS Hospice Survey. We are examining the impact of a web-based mode on survey response rates and scores. The survey currently has three approved modes without any web component (mail, telephone, and mail with telephone follow-up). In addition, the test will allow for examination of the effects of a shortened survey (that is, removing existing survey items) on response rate and scores; assessment of the measure properties of a limited number of supplemental survey items suggested by stakeholders; and calculation of item-level mode adjustments for the shortened survey in the currently-approved modes of CAHPS Hospice Survey administration, as well as the proposed new web-based mode.

The mode experiment design applied all of the existing CAHPS Hospice Survey eligibility criteria, and sampled patients/caregivers across five arms. The first arm tested a new web-mail mode, in which invitations to the web survey were sent by email to those with email addresses. The email was personalized to the respondent and included a link to the web version of the survey, which can be completed on either a computer or a mobile device such as a smartphone or tablet. If the respondent did not complete the web survey after one week, or did not have a valid email address in which to send an email, up to two surveys were sent by mail. This arm used a shortened version of the CAHPS Hospice Survey.

In the next three arms, the shortened version of the CAHPS Hospice Survey instrument was administered in the three currently-approved modes: mail only; telephone-only; and mixed mode (mail with telephone follow up). The fifth arm, in which the current survey instrument was administered via mail only served as a comparison for all other arms. Across all arms, half of sampled caregivers received a pre-notification letter to examine the effects of such a letter on response rates.

Overall (across the five arms), CMS sampled 15,000 eligible caregivers from around 50 hospices over a six- to seven-month period. Caregivers were randomized within each hospice to one of the five arms.

We continue to analyze the results of the mode experiment and will keep stakeholders informed on any plans for changes to the survey content or administration options through our regular stakeholder communication channels. In this final rule, there are no changes to the administration procedures or content for the CAHPS Hospice Survey. Any changes to the CAHPS Hospice Survey will be proposed in future rulemaking.

We received several comments regarding the CAHPS Hospice Survey Mode Experiment. A summary of these comments and our responses to those comments are as follows:

Comment: Most commenters support the development and testing of a web-based mode and a shortened version of the CAHPS Hospice Survey.

Response: We appreciate the support of a web-based mode of survey administration and shorter CAHPS Hospice Survey instrument. Currently, CMS is completing analyses of data collected through a field test that included the web-based mode of survey administration and revisions to the survey. If and when a web-based mode is made available as one of the approved modes of CAHPS Hospice Survey administration, hospices would continue to have the option to choose among all approved modes (that is, web-based mode would not be required). Prior to introducing a revised survey instrument and/or new approved mode of administration, CMS will release detailed information regarding proposed changes to survey instrument content, survey administration protocols, and data adjustment procedures needed to promote fair comparisons between hospices selecting different modes of survey administration.

Comment: Some commenters stated that CMS should examine the CAHPS Hospice Survey to ensure questions are appropriate for ethnically diverse families and provide information that can be used to address health equity.

Response: We will continue to use data from hospices participating in the CAHPS Hospice Survey to assess how care experiences vary for subpopulations across hospices. In 2021, CMS conducted an experiment of a revised version of the CAHPS Hospice Survey that included new survey questions designed to assess cultural sensitivity of care and identify disparities in care by race and ethnicity. We will share information about the results of this test as it becomes available.

Comment: Some commenters stated that CMS should compare response rates to the CAHPS Hospice Survey and other CAHPS surveys for non-English speaking individuals to assess whether these rates vary from English-speaking individuals.

Response: We thank commenters for this feedback and will take this suggestion into consideration. Data has shown for other CAHPS surveys that the likelihood of responding to survey differs by race/ethnicity and mode. We encourage hospices to consider their patient/caregiver population and work with their survey vendor to determine the best mode of data collection.

Comment: One commenter stated that the CAHPS Hospice Survey is not an accurate reflection of care received since the primary caregiver completes the survey.

Response: The Hospice CAHPS Survey is completed by the primary caregiver out of respect for the patient receiving end of life care. We do not feel it would be appropriate to have hospice patients fill out a survey about the care they are receiving at the very end of their life.

d. Data Sources

In the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38484), we finalized the participation requirements for the CAHPS Hospice Survey. To meet the CAHPS Hospice Survey requirements for the HQRP, hospice facilities must contract with a CMS-approved vendor to collect survey data for eligible patients on a monthly basis and report that data to CMS on the hospice's behalf by the quarterly deadlines established for each data collection period.

e. Public Reporting of CAHPS Hospice Survey Results

We began public reporting of the results of the CAHPS Hospice Survey on Hospice Compare as of February 2018. Before the COVID–19 PHE, we reported the most recent 8 quarters of data on the basis of a rolling average, with the most recent quarter of data being added and the oldest quarter of data removed from the averages for each data refresh. As finalized in the FY 2022 Hospice Wage Index and Payment Rule Update (86 FR 42528), we are not reporting Q1 2020 and Q2 2020 data due to the COVID–19 PHE. Therefore, we have publicly reported the most recently available 8 quarters of CAHPS data that excluded Q1 2020 and Q2 2020 data. These data were publicly reported starting with the February 2022 refresh and will continue through the May 2023 refresh on Care Compare. The Second Edition HQRP Public Reporting Tip Sheet dated Dec. 2021 on the *HQRP Requirements and Best Practices web page* summarizes CMS' approach to the HQRP as public reporting has resumed in February 2022. It also explains the HQRP public reporting changes associated with the FY 2022 Hospice Wage Index and Payment Rule Update final rule and provides a summary of the data refreshes.

f. Volume-Based Exemption for CAHPS Hospice Survey Data Collection and Reporting Requirements

In the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38526), we finalized a policy making a volume-based exemption for CAHPS Hospice Survey Data Collection and Reporting requirements for FY 2021 and every year thereafter.

In this final rule, there will be no changes to this exemption. The exemption request form is available on the official CAHPS Hospice Survey website: *http://www.hospiceCAHPSsurvey.org.* Hospices that intend to claim the size exemption are required to submit to CMS their completed exemption request form by December 31, of the data collection year.

Hospices that served a total of fewer than 50 survey-eligible decedent/caregiver pairs in the year before the data collection year are eligible to apply for the size exemption. Hospices may apply for a size exemption by submitting the size exemption request form. The size exemption is only valid for the year on the size exemption request form. If the hospice remains eligible for the size exemption, the hospice must complete the size exemption request form for every applicable FY APU period, as shown in Table 6.

TABLE 6: Size Exemption Key Dates FY 2023 Through FY 2026

Fiscal year	Data collection year	Reference year	Size exemption form submission deadline
FY 2023	CY 2021	CY 2020	December 31, 2021
FY 2024	CY 2022	CY 2021	December 31, 2022
FY 2025	CY 2023	CY 2022	December 31, 2023
FY 2026	CY 2024	CY 2023	December 31, 2024

g. Newness Exemption for CAHPS Hospice Survey Data Collection and Public Reporting Requirements

We previously finalized a one-time newness exemption for hospices that meet the criteria as stated in the FY 2017 Hospice Wage Index and Payment Rate Update final rule (81 FR 52181). In the FY 2019 Hospice Wage Index and Payment Rate Update final rule (83 FR 38642), we continued the newness exemption for FY 2023, and all subsequent years. We encourage hospices to keep the letter they receive providing them with their CMS Certification Number (CCN). The letter can be used to show when you received your number.

h. Survey Participation Requirements

We previously finalized survey participation requirements for FY 2022 through FY 2025 as stated in the FY 2018 and FY 2019 Hospice Wage Index and Payment Rate Update final rules (82 FR 36670 and 83 FR 38642 through 38643). We also continued those requirements in all subsequent years (84 FR 38526). Table 7 restates the data submission dates for FY 2023 through FY 2025.

TABLE 7: CAHPS Hospice Survey Data Submission Dates for the APU in FY 2023, FY 2024, and FY 2025

Sample months (month of death)*	CAHPS Quarterly Data Submission Deadlines**
FY 2023 APU	
CY January-March 2021 (Quarter 1)	August 11, 2021
CY April-June 2021 (Quarter 2)	November 10, 2021
CY July-September 2021 (Quarter 3)	February 9, 2022
CY October-December 2021 (Quarter 4)	May 11, 2022
FY 2024 APU	
CY January-March 2022 (Quarter 1)	August 10, 2022
CY April-June 2022 (Quarter 2)	November 9, 2022
CY July-September 2022 (Quarter 3)	February 8, 2023
CY October-December 2022 (Quarter 4)	May 10, 2023
FY 2025 APU	
CY January-March 2023 (Quarter 1)	August 9, 2023
CY April-June 2023 (Quarter 2)	November 8, 2023
CY July-September 2023 (Quarter 3)	February 14, 2024
CY October-December 2023 (Quarter 4)	May 8, 2024

* Data collection for each sample month initiates 2 months following the month of patient death (for example, in April for deaths occurring in January).

** Data submission deadlines are the second Wednesday of the submission months, which are the months August, November, February, and May.

For further information about the CAHPS Hospice Survey, we encourage hospices and other entities to visit: *https://www.hospiceCAHPSsurvey.org.* For direct questions, contact the CAHPS Hospice Survey Team at *hospicecahpssurvey@hsag.com* or call 1 (844) 472–4621.

i. CAHPS Hospice Survey Star Ratings

We previously finalized a policy requiring us to display Hospice CAHPS Survey Star Ratings no sooner than FY 2022 as stated in the FY 2022 Hospice Wage Index and Payment Rule Update rule (86 FR 42528). Star Ratings will be publicly reported on Care Compare on Medicare.gov beginning with the August 2022 refresh. This start date allowed CMS to conduct a dry run of the Star Ratings with reporting to hospices via preview reports. Hospices first saw their Star Ratings in their preview reports during the November 2021 and March 2022 preview periods for the February 2022 and May 2022 updates of Care Compare on *Medicare.gov*. However, the CAHPS Hospice Survey Star Ratings will not be publicly reported in February or May 2022. The reporting period for the dry run covers data from Q4 2018 through Q4 2019 and Q3 2020 through Q1 2021. Detailed information about the calculation and display of Hospice CAHPS Survey Star Ratings can be found on the official CAHPS Hospice Survey website: *http://www.hospiceCAHPSsurvey.org.* There are no changes to the Hospice CAHPS Survey Star Ratings for FY 2023.

We received several comments regarding the CAHPS Survey Star Ratings. A summary of these comments and our responses to those comments are as follows:

Comment: Some commenters expressed concerns that Star Ratings will only include data from the CAHPS Hospice Survey and therefore will not provide consumers with all the relevant information to decide on selecting a hospice.

Response: Star Ratings using CAHPS Hospice Survey data is an initial step CMS is taking to provide consumers with an easy to understand method for comparing hospices. We will take the feedback to include other data sources into consideration as enhancements are made over time.

Comment: A handful of commenters raised concern that low survey response rates will prevent hospices from being assigned a Star Rating and this could result in fewer hospices having Star Ratings. Several commenters stated that it is not clear how a consumer will perceive a hospice that is not assigned a Star Ratings.

Response: CMS recently tested a web mode and shortened questionnaire with the goal of improving response rates. We are analyzing the data for potential future changes to the Hospice CAHPS Survey. For the August 2022 reporting period, most hospices with publicly reported CAHPS Hospice Survey measure scores (68 percent) met the threshold of 75 completed surveys and were assigned a Star Rating. The vast majority of 2020 Medicare decedents (approximately nine out of ten) received care from hospices that received a Star Rating in August 2022. CMS presents footnotes and other documentation on the Care Compare website to clearly indicate why hospices with smaller numbers of completed surveys do not have Star Ratings.

Comment: A commenter suggested that Star Ratings be calculated based on absolute rather than relative performance.

Response: Similar to other CMS CAHPS Star Ratings, CMS finalized that the cut-point methodology used to determine CAHPS Hospice Survey stars use statistical clustering procedures that minimize the score differences within a star category and maximize the differences across star categories. This ensures that star assignments clearly differentiate performance across groups of hospices. Such comparative Star Ratings help consumers identify high and low performing hospices. Statistical clustering also allows cut points to adjust for unanticipated changes in performance within the industry. Setting absolute cut points has multiple issues, including variation in industry performance across measures, external or structural factors can lead to substantial changes from period to period rather than steady, slow year-over-year improvement, and diminished incentive to improve when a hospice knows they have reached a certain pre-established performance threshold.

Comment: A couple of commenters shared concerns that the time period of data used to calculate quality measures, including Star Ratings for the CAHPS Hospice Survey, includes data up to 3 years old which undermines the usefulness of the information being publicly reported.

Response: Rolling up eight quarters of data instead of four ensures that measure scores are available for many more hospices, which improves the usefulness of the Compare web tools for hospice consumers. The eight-quarter approach does not result in a delay of when data becomes available (since the most recent quarters of data are included in the rolled-up score), but it does ensure more accurate measurement. The decision to use eight quarters of rolling data for hospices reflects sample size issues that are specific to hospice organizations, which differ in size and other dimensions from other types of entities, such as hospitals and MA contracts, for which CMS publicly reports scores and Star Ratings.

5. Form, Manner, and Timing of Quality Data Submission

a. Statutory Penalty for Failure To Report

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. Such data must be submitted in a form and manner, and at a time specified by the Secretary. Section 1814(i)(5)(A)(i) of the Act was amended by the CAA 2021 and the payment reduction for failing to meet hospice quality reporting requirements is increased from 2 percent to 4 percent beginning with FY 2024. The Act requires that, beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and then beginning in FY 2024 and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that fiscal year. Last year, we revised our rule at § 418.306(b)(2) in accordance with this statutory change (86 FR 42605).

b. Compliance

HQRP Compliance requires understanding three timeframes for both HIS and CAHPS: (1) The relevant Reporting Year, payment FY and the Reference Year. The ''Reporting Year'' (HIS)/''Data Collection Year'' (CAHPS). This timeframe is based on the calendar year. It is the same CY for both HIS and CAHPS. If the CAHPS Data Collection year is CY 2023, then the HIS reporting year is also CY 2023; (2) The APU is subsequently applied to FY payments based on compliance in the corresponding Reporting Year/Data Collection Year; and (3) For the CAHPS Hospice Survey, the Reference Year is the CY prior to the Data Collection Year. The Reference Year applies to hospices submitting a size exemption from the CAHPS survey (there is no similar exemption for HIS). For example, for the CY 2023 data collection year, the Reference Year, is CY 2022. This means providers seeking a size exemption for CAHPS in CY 2023 will base it on their hospice size in CY 2022. Submission requirements are codified in § 418.312.

For every CY all Medicare-certified hospices are required to submit HIS and CAHPS data according to the requirements in § 418.312. Table 8 summarizes the three timeframes. It illustrates how the CY interacts with the FY payments, covering the CY 2021 through CY 2024 data collection periods and the corresponding APU application from FY 2023 through FY 2026.

TABLE 8: HQRP Reporting Requirements and Corresponding Annual Payment Updates

Reporting Year for HIS and Data Collection Year for CAHPS data (Calendar year)	Annual Payment Update Impacts Payments for the FY	Reference Year for CAHPS Size Exemption (CAHPS only)
CY 2021	FY 2023 APU	CY 2020
CY 2022	FY 2024 APU*	CY 2021
CY 2023	FY 2025 APU	CY 2022
CY 2024	FY 2026 APU	CY 2023

* Beginning in FY 2024 and all subsequent years, the payment penalty is 4 percent. Prior to FY 2024, the payment penalty is 2 percent.

As illustrated in Table 8, CY 2021 data submissions compliance impacts the FY 2023 APU. CY 2022 data submissions compliance impacts the FY 2024 APU. CY 2023 data submissions compliance impacts FY 2025 APU. This CY data submission impacting FY APU pattern follows for subsequent years.

c. Submission Data and Requirements

As finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142, 47192), hospices' compliance with HIS requirements beginning with the FY 2020 APU determination (that is, based on HIS–Admission and Discharge records submitted in CY 2018) are based on a timeliness threshold of 90 percent. This means CMS requires that hospices submit 90 percent of all required HIS records within 30-days of the event (that is, patient's admission or discharge). The 90-percent threshold is hereafter referred to as the timeliness compliance threshold. Ninety percent of all required HIS records must be submitted and accepted within the 30-day submission deadline to avoid the statutorily-mandated payment penalty. Hospice compliance with claims data requirements is based on administrative data collection. Since Medicare claims data are already collected from claims, hospices are considered 100 percent compliant with the submission of these data for the HQRP. There is no additional submission requirement for administrative data.

To comply with CMS' quality reporting requirements for CAHPS, hospices are required to collect data monthly using the CAHPS Hospice Survey. Hospices comply by utilizing a CMS-approved third-party vendor. Approved Hospice CAHPS vendors must successfully submit data on the hospice's behalf to the CAHPS Hospice Survey Data Center. A list of the approved vendors can be found on the CAHPS Hospice Survey website: *www.hospicecahpssurvey.org.* Table 9. HQRP Compliance Checklist illustrates the APU and timeliness threshold requirements.

TABLE 9: HQRP Compliance Checklist

Annual Payment Update	HIS	CAHPS
FY 2023	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/21 – 12/31/21.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2021 – 12/31/2021
FY 2024	Submit at least 90 percent of all HIS records or its successor instrument within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/22 – 12/31/22.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2022 – 12/31/2022
FY 2025	Submit at least 90 percent of all HIS records or its successor instrument within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/23 – 12/31/23.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2023 – 12/31/2023

Note: The data source for the claims-based measures will be Medicare claims data that are already collected and submitted to CMS. There is no additional submission requirement for administrative data (Medicare claims), and hospices with claims data are 100-percent compliant with this requirement.

Most hospices that fail to meet HQRP requirements do so because they miss the 90 percent threshold. We offer many training and education opportunities through our website, which are available 24/7, 365 days per year, to

enable hospice staff to learn at the pace and time of their choice. We want hospices to be successful with meeting the HQRP requirements. We encourage hospices to use the website at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training-Training-and-Education-Library.* For more information about HQRP Requirements, we refer readers to visit the frequently-updated HQRP website and especially the Best Practice, Education and Training Library, and Help Desk web pages at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting.* We also encourage readers to visit the HQRP web page and sign-up for the Hospice Quality ListServ to stay informed about HQRP.

6. Request for Information Related to the HQRP Health Equity Initiative

CMS defines health equity as ''the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.'' CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive. CMS' goals are in line with Executive Order 13985, on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, which can be found at: *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.*

Belonging to an underserved community is often associated with worse health outcomes.[4] [5] [6] [7] [8] [9] [10] [11] Such disparities in health outcomes are the result of multiple factors. Although not the sole determinants, poor access to care and provision of lower quality health care are important contributors to health disparities notable for CMS programs. Health inequities persist in hospice and palliative care, where Black and Hispanic populations are less likely to utilize care and over 80 percent of patients are White.[12] [13] [14] [15] After hospice admission, racial and ethnic disparities appear to impact quality of care and health outcomes.[16] Black patients may receive fewer supportive care medications despite higher symptom burdens, experience care less consistent with their expressed preferences, and encounter worse end-of-life communication.[17] [18] [19] [20] [21] In response to a survey regarding these disparities, 70 percent of home health organizations, including 22 percent that are hospices, indicated they would increase the resources dedicated to diversity, equity, and inclusion starting in 2021.[22] One important strategy for addressing these disparities is improving data collection to allow for better measurement and reporting on equity across our programs and policies.[23] [24]

We are committed to achieving equity in health care outcomes for our beneficiaries by supporting providers in quality improvement activities to reduce health inequities, enabling beneficiaries to make more informed decisions, and promoting provider accountability for health care disparities.[25] [26] CMS is committed to closing the equity gap in CMS quality programs. As discussed in the RFI from the FY 2022 Hospice Wage Index and Rate Update proposed rule (86 FR 19700), we are focused at making information on the quality of health care providers and services, including disparities, more transparent.

In the FY 2022 Hospice Wage Index and Rate Update final rule, we received comments supportive of gathering standardized patient assessment data elements and additional SDOH data to improve health equity. In parallel, commenters advocated for education efforts for beneficiaries, providers, and stakeholders on the benefits of collecting and reporting demographic and social risk factor data. We received many comments about the use of standardized patient assessment data elements in the hospice setting to assess health equity and SDOH, some of which raised concerns around whether such use may have unintended consequences. Many commenters noted that hospice patients have different goals of care than non-hospice patients, which does not align with standardized

[4] Joynt KE, Orav E, Jha AK. Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care. JAMA. 2011; 305(7):675–681.

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[6] Trivedi AN, Nsa W, Hausmann LRM, et al. Quality and Equity of Care in U.S. Hospitals. New England Journal of Medicine. 2014; 371(24):2298–2308.

[7] Polyakova, M., et al. Racial Disparities In Excess All-Cause Mortality During The Early COVID–19 Pandemic Varied Substantially Across States. Health Affairs. 2021; 40(2): 307–316.

[8] Rural Health Research Gateway. Rural Communities: Age, Income, and Health Status. Rural Health Research Recap. November 2018.

[9] *https://www.minorityhealth.hhs.gov/assets/PDF/Update_HHS_Disparities_Dept-FY2020.pdf.*

[10] *www.cdc.gov/mmwr/volumes/70/wr/mm7005a1.htm.*

[11] Poteat TC, Reisner SL, Miller M, Wirtz AL. COVID–19 Vulnerability of Transgender Women With and Without HIV Infection in the Eastern and Southern U.S. Preprint. medRxiv. 2020;2020.07.21.20159327. Published 2020 Jul 24. doi:10.1101/2020.07.21.20159327.

[12] Addressing Disparities in Hospice & Palliative Care. Nalley, Catlin. Oncology Times: March 20, 2021—Volume 43—Issue 6—p 1,10doi: 10.1097/01.COT.0000741732.73529.bb.

[13] *https://journalofethics.ama-assn.org/article/racial-disparities-hospice-moving-analysis-intervention/2006-09.*

[14] Capital Caring, Seasons Execs: Improving Hospice Diversity Starts from the Inside Out. 11/17/21. Holly Vossel. Capital Caring, Seasons Execs: Improving Hospice Diversity Starts from the Inside Out—Hospice & Palliative Care Network of Maryland *https://hospicenews.com/2021/11/17/capital-caring-seasons-execs-improving-hospice-diversity-starts-from-the-inside-out/.*

[15] Disparities in Palliative and Hospice Care and Completion of Advance Care Planning and Directives Among Non-Hispanic Blacks: A Scoping Review of Recent Literature (*nih.gov*).

[16] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3822363/.*

[17] Naming the Problem: A Structural Racism Framework to Examine Disparities in Palliative Care—ScienceDirect.

[18] Johnson KS. Racial and ethnic disparities in palliative care. J Palliat Med 2013;16:1329–1334.

[19] Elk R, Felder TM, Cayir E, Samuel CA. Social inequalities in palliative care for cancer patients in the United States: a structured review. Semin Oncol Nurs 2018;34:303–315.

[20] Elliott AM, Alexander SC, Mescher CA, Mohan D, Bar-nato AE. Differences in physicians' verbal and nonverbal communication with black and white patients at the end of life. J Pain Symptom Manage 2016;51:1–8.

[21] Johnson RL, Roter D, Powe NR, Cooper LA. Patient race/ethnicity and quality of patient-physician communication during medical visits. Am J Public Health 2004;94:2084–2090.

[22] Capital Caring, Seasons Execs: Improving Hospice Diversity Starts from the Inside Out. 11/17/21. Holly Vossel. Capital Caring, Seasons Execs: Improving Hospice Diversity Starts from the Inside Out—Hospice & Palliative Care Network of Maryland *https://hospicenews.com/2021/11/17/capital-caring-seasons-execs-improving-hospice-diversity-starts-from-the-inside-out/.*

[23] *https://hospicenews.com/2021/05/27/hospice-providers-leverage-data-to-reach-the-underserved/.*

[24] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3822363/.*

[25] *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf.*

[26] Report to Congress: Improving Medicare PostAcute Care Transformation (IMPACT) Act of 2014 Strategic Plan for Accessing Race and Ethnicity Data. January 5, 2017. Available at *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Research-Reports-2017-Report-to-Congress-IMPACT-ACT-of-2014.pdf.*

data elements for patient assessment. Commenters encouraged CMS to only utilize certain aspects of standardized data elements for patient assessment (specifically, Z-codes 55–65) in collecting health equity data. We refer the readers to review the summary of public comments received in the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42528).

We will continue to take all comments and suggestions into account as we work to develop policies on this important topic. We appreciate hospices and national organizations sharing their support and commitment to addressing health disparities and offering meaningful comments for consideration in the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42528). Given the value of the comments thus far and the ongoing development of activities to improve health equity, we solicited public comment in the proposed rule on the following questions:

- What efforts does your hospice employ to recruit staff, volunteers, and board members from diverse populations to represent and serve underserved populations?
- How does your hospice attempt to bridge any cultural gaps between your personnel and beneficiaries/clients?
- How does your hospice measure whether this has an impact on health equity?
- How does your hospice currently identify barriers to access in your community or service area?
- What are barriers to collecting data related to disparities, social determinants of health, and equity?
- What steps does your hospice take to address these barriers?
- How does your hospice collect self-reported data such as race/ethnicity, veteran status, socioeconomic status, housing, food security, access to interpreter services, caregiving status, and marital status and use this to inform its health equity initiatives?
- How is your hospice using qualitative data collection and analysis methods to measure the impact of its health equity initiatives?

We received several comments in response to our request for information on the HQRP Health Equity initiative. A summary of these comments and our responses to those comments are as follows:

Comment: Many commenters supported CMS's efforts to create health equity measures. However, commenters wanted more clarity on CMS's plans for health equity measures and what measurement criteria CMS would consider applying to hospices. Comments suggested that CMS should encourage all health care providers and organizations across the continuum of care to collect and stratify patient and caregiver data based on key variables of inequities in patient care for all types of measures.

Comment: Commenters reiterated and acknowledged health disparities in hospice care and were broadly supportive of CMS' efforts to advance health equity and generally expressed appreciation for the opportunity to partner with CMS to address disparities in hospice settings. Many shared their organization's efforts to promote health equity, including staff training and hiring. Despite the overall appreciation, commenters noted that there is great variation in organizational readiness to develop and implement health equity initiatives; for example, hospice providers serving smaller rural communities may not be as far along in integrating health equity activities as larger providers associated with robust hospital systems. Similarly, other comments noted that, to varying degrees, providers may experience the following challenges in implementing a health equity framework and respective quality improvement activities: financial limitations, data collection burden, and workforce shortages. In light of these considerations, commenters requested CMS support in the form of financial and other resources (for example, trainings), ample time for hospices to develop and implement activities to improve health equity, and the use of incentive-based rather than punitive measures to promote reporting. One commenter recommended stratifying the volume and detail of data collected based on the size, independence, and geographic profile of a given hospice. Some suggested convening a Technical Expert Panel (TEP) to inform the development of health equity measures until after HOPE becomes available.

Several commenters highlighted the need for more sociodemographic and social determinants of health (SDOH) data to effectively evaluate health equity in hospice settings. Commenters suggested efforts to standardize the sociodemographic and SDOH data collected across provider settings and across third party vendors (for example, EMRs) and other tools. There was some support for the stratification of confidential data reports by sociodemographic factors. Multiple commenters also recommended incorporating SDOH items into HOPE and delaying public reporting of a health equity measure until HOPE is available.

Comment: Commenters stated that some hospice providers have made progress in recruiting and employing diverse staff to better represent historically underserved populations. Successful strategies have included job marketing and community outreach, educational efforts and partnering with colleges and universities, developing partnerships with groups and associations to promote employment and leadership opportunities, development of diversity, equity, and inclusion (DEI) recruitment teams,[27] sign on bonuses for certain qualifications (for example, bilingual), and scholarships for staff who are members of disproportionately affected populations. Several commenters highlighted the wide variation across hospices with regards to resources and progress made in diversity of staff and leadership and stated that smaller organizations may need additional resources and support to implement recruitment and retention efforts. Other commenters stated that a limited pool of applicants due to workforce shortages is a major challenge across all organizations. One commenter stated that hospice workforce diversity is not necessarily reflective of the diversity in the underlying community and that this is a broader issue which will need to be addressed through coordinated efforts, such as, to recruit more diverse student populations in healthcare and social work programs. Approaches to bridge cultural gaps between personnel and beneficiaries include community outreach and partnerships, DEI training for staff and leadership, DEI organizational assessments, centering equity in organizational mission, values, and goals, and expansion of linguistic capacities.

Comment: Several commenters responded to CMS's request for information about barriers that might prevent community members from seeking hospice care. Commenters reported that strategies to identify and address barriers include training staff, building partnerships, employing community liaisons to work with patients and caretakers, including social determinant of health (SDOH) information in social work assessments and workplans (for example, housing and food insecurity), using toolkits and resources freely available to the public on websites, including national hospice organizations' websites, and working

[27] Diversity recruiting is the practice of hiring candidates using a process that is free from bias for or against any individual or group of candidates. Diverse teams help companies to be more innovative, be more creative, and achieve better results. *https://www.dictionary.com/*.

with EMR vendors to better collect sociodemographic information.

Comment: Many commenters cited barriers to collecting data related to disparities, social determinants of health, and equity. Those barriers included a lack of uniformity and interoperability across EMRs and other tools, lack of standard definitions for sociodemographic and SDOH variables, limited communication channels for administering CAHPS and other data collection instruments, patient mistrust in providing these data, and the administrative burden of data collection.

Commenters provided recommendations to address these barriers such as the standardization of sociodemographic and SDOH data collected across systems, the use of a universal database, and the inclusion of new codes that measure patients' SDOH needs (Z codes) into hospice claims.

Comment: Commenters reported variation in how self-reported data to inform health equity are collected across hospice providers; some collect these data at referral or admissions, while others collect during social work or psychosocial assessments. Some providers are not yet collecting these data and request additional guidance. Although certain sociodemographic or social determinant of health (SDOH) data points are collected through EMR fields, commenters identified issues related to the use of these data. The issues include lack of industry standards noted by several commenters in definitions for these variables and the limits of the EMR system in how the data is stored that impacts the ability to share the data. For example, one commenter described limits with sharing the data because some self-reported variables (for example, race/ethnicity) are collected in parts of the EMR that cannot be easily shared while other variables (for example, need for interpreter services and food insecurity) are collected through other parts of the EMR system and can be shared with partner organizations for referrals and other purposes. Another commenter stated that staff at an organization can use different versions of an EMR, which results in inconsistencies in data.

Many commenters expressed a need for guidance on how to collect health equity related data (for example, sociodemographic and SDOH data points) and how to effectively use them to assess health equity impacts. Commenters indicated a strong need to identify effective methods for collecting sociodemographic and SDOH data among hospice providers. Specifically, several commenters recommended the inclusion of languages other than English (for example, need for bilingual services), whether culture was respected, sexual orientation and gender identity, expanded racial/ethnic categories to capture more detailed information, socioeconomic status, food security, community deprivation level, and caregiving status information. Suggested tools for collecting some of these data points included the CAHPS® Hospice Survey, the anticipated HOPE tool, and use of Z codes on hospice claims.

Comment: Commenters stated that most hospice providers have not yet implemented initiatives to measure the impact of health equity initiatives with qualitative data. Some hospice providers stated that they collect qualitative social determinant of health information through admissions or social work assessments. Commenters requested guidance to support better qualitative data collection and analysis and sought examples of how this has been done. Several commenters requested consideration of the wide variety of existing support, infrastructure, and funding across hospice providers when determining support, flexibility, and requirements related to health equity measurement initiatives.

Response: CMS appreciates all stakeholder feedback received on this request for information. These comments will help inform CMS's future efforts to incorporate health equity and social determinants of health into the HQRP. CMS remains committed to creating meaningful quality measures based on robust and accurate data that follows the Meaningful Measures Framework and Blueprint, without imposing unnecessary burden on providers.

In addition, we sought comments on a future structural composite measure that would address aspects of health equity. Specifically, the structural composite measure could include organizational activities to address access to and the quality of hospice care for underserved populations. The composite structural measure concept could include hospice reported data on hospice activities to address underserved populations' access to hospice care. For example, a hospice could receive a point for each domain where data are submitted to a CMS portal, regardless of the hospice's action in that domain (such as, reporting whether or not the hospice provided training for board members, leaders, staff and volunteers in culturally and linguistically appropriate services (CLAS), health equity, and implicit bias). The data could reflect the hospice's completed actions for each corresponding domain (for a total of three points) in a reporting year. A hospice could submit information such as documentation, examples, or narratives to qualify for the measure numerator. We solicited comments on how to score a domain for a hospice that submitted data reflecting no actions or partial actions in the given domain.

Examples of the domains we considered are described in the following outline. We solicited comment on each of these domains.

Domain 1: Hospice commitment to reducing disparities is strengthened when equity is a key organizational priority. Candidate domain 1 could be satisfied when a hospice submits data on its actions regarding the role of health equity and community engagement in their strategic plan. Hospices could self-report data in the reporting year about their actions in each of the following areas, and submission of data for all elements could be required to qualify for the measure numerator.

- Hospice attests whether its strategic plan includes approaches to address health equity in the reporting year.
- Hospice reports community engagement and key stakeholder activities in the reporting year.
- Hospice reports on any attempts to measure input from patients and caregivers about care disparities it may experience and recommendations or suggestions.

Domain 2: Training board members, leaders, staff and volunteers in culturally and linguistically appropriate services (CLAS),[28] health equity, and implicit bias is an important step hospices take to provide quality care to diverse populations. Candidate domain 2 could focus on hospices' diversity, equity, inclusion and CLAS training for board members, employed staff, and volunteers by capturing the following self-reported actions in the reporting year. Submission of relevant data for all elements could be required to qualify for the measure numerator.

- Hospice attests whether employed staff were trained in CLAS and culturally sensitive care mindful of social determinants of health (SDOH) in the reporting year. Example data include specific training programs or training requirements for staff.
- Hospice attests whether it provided resources to staff and volunteers about health equity, SDOH, and equity

[28] *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf.*

initiatives in the reporting year. Examples include the materials provided, webinars, or learning opportunities.

Domain 3: Leaders and staff could improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. This candidate domain could capture activities related to organizational inclusion initiatives and capacity to promote health equity. Examples of equity-focused factors include proficiency in languages other than English, experience working with populations in the service area, experience working on health equity issues, and experience working with individuals with disabilities.

Submission of relevant data for all elements could be required to qualify for the measure numerator.

- Hospice attests whether equity-focused factors were included in the hiring of hospice senior leadership, including chief executives and board of trustees, in the previous reporting year.
- Hospice attests whether equity-focused factors were included in the hiring of hospice senior leadership, including chief executives and board of trustees, is more reflective of the services area patient than in the previous reporting year.
- Hospice attests whether equity-focused factors were included in the hiring of direct patient care staff (for example, RNs, medical social workers, aides, volunteers, chaplains, or therapists) in the previous reporting year.
- Hospice attests whether equity focused factors were included in the hiring of indirect care or support staff (for example. administrative, clerical, or human resources) in the previous reporting year.

We stated that we are interested in developing health equity measures based on information collected by hospices not currently available on claims, assessments, or other publicly available data sources to support development of future quality measures. We solicited public comments on the conceptual domains and quality measures described in this section. Furthermore, we solicited public comments on publicly reporting a composite structural health equity quality measure; displaying descriptive information on Care Compare from the data hospices provide to support health equity measures; and the impact of the domains and quality measure concepts on organizational culture change.

We received several comments regarding the request for information related to a health equity structural composite measure. A summary of the comments and our responses to those comments are as follows:

Comment: Commenters were generally supportive of developing a health equity structural composite measure but recommended a number of steps for CMS to take prior to implementation and publishing of the measure. Commenters emphasized the need to engage stakeholders and strongly supported the convening of a TEP to guide the development of the health equity structural composite measure. Several commenters also requested that providers have an opportunity to review, analyze, and learn from results of the structural measure prior to CMS implementation.

Comments focused on balancing administrative and resource burdens with the benefit of the information gathered. It was suggested that CMS leverage existing data collection tools and prioritize standardization of data collected across providers. Commenters also requested assurance that the data gathered be accurate, meaningful, and actionable. Several commenters recommended that the measure more explicitly incorporate social determinants of health data. Some commenters stated that there should be a focus on the impact of health equity-related activities on patient outcomes and disparities, in addition to the domains that are discussed.

Several commenters suggested that hospice providers will need tools such as trainings, improved health IT interoperability, or other additional resources, and sufficient time to incorporate a health equity framework into their daily practice prior to beginning data collection for a structural composite measure. This was especially highlighted as a concern for under-resourced providers serving smaller and rural communities. Additionally, commenters requested that CMS postpone public reporting of hospice health equity measures to allow for HOPE implementation, testing of health equity metrics in other settings of care, and pilot testing of the structural composite measure.

Comment: Commenters recognized strategic plans are a starting point to improve health equity, and supported a structural measure domain based on organizational commitment to health equity and community engagement in strategic planning. Some commenters recommended that CMS provide more specifics regarding information to be collected from the strategic plan, such as how disparities are being measured and by which tools. Some commenters encouraged CMS to ensure that measures related to this domain provide meaningful information about an organization's engagement and partnership with stakeholders. Commenters suggested measures such as providing education on the hospice benefit to targeted demographics, facilitating communication among providers and community partners, and finding ways to engage community members in nontraditional settings to reach patients who might not otherwise receive needed hospice care. There was also a concern that this domain would not assess whether outcomes are improved as a result of making equity a key organizational priority.

Some commenters suggested that the CAHPS® Hospice Survey could be revised to include additional questions regarding caregiver experience and recommendation for improvement, but also pointed out that caregivers may not be able to answer such questions due to limited exposure to hospice before hospice election. Commenters requested hospices be afforded the time and tools to incorporate a health equity framework into their daily practices before data collection for this domain commences. One commenter recommended that CMS develop standards related to this data collection, to facilitate hospice implementation. Another commenter requested the opportunity to provide feedback on the measure once developed and prior to public reporting of data for this domain. Additionally, some commenters suggested convening a TEP to further develop this domain.

Comment: Commenters generally supported and appreciated the attention toward culturally and linguistically appropriate services (CLAS) training and other health equity trainings. In addition to supporting cultural sensitivity efforts, several commenters recognized that efforts to improve organizational understanding of social determinants of health (SDOH) are equally needed. They recommended collecting data on SDOH and sociodemographic factors that may lead to poor outcomes. Specifically, respondents suggested collecting data on access to healthy foods, neighborhood safety, housing stability, income level, education quality, and transportation availability.

Regarding CLAS and health equity trainings, one commenter suggested requesting more specific information such as training content, frequency, training evaluation results, and any documentation of patient or family member experience with CLAS received. Some commenters suggested

CMS develop or approve evidence-based trainings and/or certification available without imposing a financial burden on hospices.

Comments were mixed when considering the collection of information for this domain, with some respondents asking for more detailed data collection requirements. There was some concern about the financial burden of providing additional trainings for certain staff. Lastly, there was a request to allow hospices a period of time to become familiar with CLAS and other health equity approaches prior to implementing required reporting for this domain.

Comment: Commenters were generally supportive of the concept of setting an organizational culture of equity and of considering health equity in hiring across all levels as a means of achieving equity. Some comments particularly highlighted the importance of incorporating equity-focused factors in the hiring of senior leadership roles. However, several commenters also noted that hiring practices are not the only area in which a culture of equity can be promoted. These comments stated that the current workforce shortages are leaving employers with limited applicant pools and reduced potential to give adequate weight to equity considerations during the hiring process. Given this context, these commenters stated that focusing solely on hiring practices may not be the most appropriate approach to assessing organizational culture of equity. Commenters offered several suggestions, such as evaluating existing staff capacity to address disparities, assessing patient profile concordance with community profile, and borrowing from proposed measures in hospital and skilled nursing facility settings for this domain.

Commenters recommended providing more specific definitions of each ''equity focused factor'' and asking hospice providers to report on each of the factors. Some commenters also recommended that a TEP be convened to guide the development of the measures for this domain. Lastly, some comments noted that organizational readiness and capacity may be difficult to achieve and CMS should allow hospices time to build a culture of equity prior to adopting this domain. To facilitate the institutionalization of a culture of equity, commenters recommended that CMS develop educational opportunities for providers and establish health equity board committees to provide resources and support providers' equity work.

Response: CMS appreciates the stakeholder comments received regarding a potential structural composite measure of health equity. Public input is very valuable for the continuing development of CMS' health equity quality measurement efforts and broader commitment to health equity; a key pillar of our strategic vision as further described here, *https://www.cms.gov/files/document/health-equity-fact-sheet.pdf.* CMS will take these questions and suggestions into consideration when further refining the measure concept. CMS remains committed to creating meaningful quality measures based on robust and accurate data that follows the Meaningful Measures Framework and Blueprint, without imposing unnecessary burden on providers. Continued stakeholder engagement and measure testing will be an important component of CMS's efforts to develop this structural measure.

7. Advancing Health Information Exchange Update

The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of interoperable health information technology and to promote nationwide health information exchange to improve health care and patient access to their digital health information.

To further interoperability in post-acute care settings, CMS and the Office of the National Coordinator for Health Information Technology (ONC) participate in the Post-Acute Care Interoperability Workgroup (PACIO) to facilitate collaboration with industry stakeholders to develop Health Level Seven International® (HL7) Fast Healthcare Interoperability Resources® (FHIR) standards.[29] These standards could support the exchange and reuse of patient assessment data derived from the Minimum Data Set (MDS), Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI), LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS), Outcome and Assessment Information Set (OASIS), and other sources. The PACIO Project has focused on HL7 FHIR implementation guides for functional status, cognitive status and new use cases on advance directives, re-assessment timepoints, and Speech Language, Swallowing, Cognitive communication and Hearing (SPLASCH) pathology. We encourage PAC provider and health IT vendor participation as the efforts advance.

The CMS Data Element Library (DEL) continues to be updated and serves as a resource for PAC assessment data elements and their associated mappings to health IT standards, such as Logical Observation Identifiers Names and Codes (LOINC) and Systematized Nomenclature of Medicine Clinical Terms (SNOMED). The DEL furthers CMS' goal of data standardization and interoperability. Standards in the DEL (*https://del.cms.gov/DELWeb/pubHome*) can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA). The 2022 ISA is available at *https://www.healthit.gov/isa*.

The 21st Century Cures Act (Cures Act) (Pub. L. 114–255, enacted December 13, 2016) required HHS and ONC to take steps to further interoperability for providers and settings across the care continuum. Section 4003(b) of the Cures Act required ONC to take steps to advance interoperability through the development of a trusted exchange framework and common agreement aimed at establishing full network-to-network exchange of health information nationally. On January 18, 2022, ONC announced a significant milestone by releasing the Trusted Exchange Framework [30] and Common Agreement Version 1.[31] The Trusted Exchange Framework is a set of non-binding principles for health information exchange, and the Common Agreement is a contract that advances those principles. The Common Agreement and the incorporated by reference Qualified Health Information Network Technical Framework Version 1 [32] establish the technical infrastructure model and governing approach for different health information networks and their users to securely share clinical information with each other—all under commonly agreed to terms. The technical and policy architecture of how exchange occurs under the Common Agreement follows a network-of-networks structure, which allows for connections at different levels and is inclusive of many different types of entities at those different levels, such as health information networks, healthcare practices, hospitals, public health agencies, and Individual Access

[29] *http://pacioproject.org/.*

[30] The Trusted Exchange Framework (TEF): Principles for Trusted Exchange (Jan. 2022), *https://www.healthit.gov/sites/default/files/page/2022-01/Trusted_Exchange_Framework_0122.pdf.*

[31] Common Agreement for Nationwide Health Information Interoperability Version 1 (Jan. 2022), *https://www.healthit.gov/sites/default/files/page/2022-01/Common_Agreement_for_Nationwide_Health_Information_Interoperability_Version_1.pdf.*

[32] Qualified Health Information Network (QHIN) Technical Framework (QTF) Version 1.0 (Jan. 2022), *https://rce.sequoiaproject.org/wp-content/uploads/2022/01/QTF_0122.pdf.*

Services (IAS). For more information, we refer readers to *https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement.*

We invited readers to learn more about these important developments and how they are likely to affect hospices.

Comment: We received several comments on the information provided in this section. Commenters expressed support for efforts across CMS and ONC to advance development of standards and certification for health IT promoting health information exchange focused on enhancing person-centered longitudinal care and exchange of clinical data. Commenters specifically recommended that CMS and ONC develop guidance and expectations around the collection and sharing of SDOH information for hospices and other post-acute care providers, as well as health IT vendors serving these providers, to ensure there are consistent requirements supporting interoperability of this data.

However, commenters identified a lack of interoperable health IT in hospices and other post-acute care settings as a major barrier to sharing health information quickly and easily across care settings. Commenters indicated that hospice and other post-acute care settings were not eligible for previous incentives to purchase technology certified under the ONC Health IT Certification Program, and that this has led to disparities in adoption between post-acute care and other settings that have received incentives. Commenters recommended that HHS continue to explore opportunities to use existing authorities to support technology adoption by hospice and other post-acute care providers in order to advance interoperability. Specific to exchange of SDOH information, commenters highlighted lack of clarity among stakeholders around how privacy rules apply to the sharing of this data as a potential barrier.

Finally, commenters provided a number of specific recommendations for new resources and enhancements to existing resources that HHS could pursue to assist hospice and other post-acute care providers with advancing data standardization.

Response: We appreciate the comments provided on interoperability initiatives and will take these comments into consideration as we coordinate with Federal partners, including ONC, on these initiatives, and to inform future rulemaking.

C. CAA 2021, Section 407. Establishing Hospice Program Survey and Enforcement Procedures Under the Medicare Program; Provisions Update

Division CC, section 407 of the CAA 2021, amended Part A of Title XVIII of the Act to add a new section 1822, and amended sections 1864(a) and 1865(b) of the Act, establishing new hospice program survey and enforcement requirements, required public reporting of survey information, and a new hospice hotline.

This law (CAA 2021) requires public reporting of hospice program surveys conducted by both State Agencies (SAs) and Accrediting Organizations (AOs), as well as enforcement actions taken as a result of these surveys, on the CMS website in a manner that is prominent, easily accessible, searchable, and presented in a readily understandable format. It removes the prohibition at section 1865(b) of the Act of public disclosure of hospice surveys performed by AOs, and requires that AOs use the same survey deficiency reports as SAs (Form CMS–2567, ''Statement of Deficiencies'' or a successor form) to report survey findings.

The law also requires hospice programs to measure and reduce inconsistency in the application of survey results among all surveyors, and requires the Secretary to provide comprehensive training and testing of SA and AO hospice program surveyors, including training with respect to review of written plans of care. The statute prohibits SA surveyors from surveying hospice programs for which they have worked in the last 2 years or in which they have a financial interest, requires hospice program SAs and AOs to use a multidisciplinary team of individuals for surveys conducted with more than one surveyor to include at least one registered nurse, and provides that each SA must establish a dedicated toll-free hotline to collect, maintain, and update information on hospice programs and to receive complaints.

The provisions in the CAA 2021 also direct the Secretary to create a Special Focus Program (SFP) for poor-performing hospice programs, set out authority for imposing enforcement remedies for noncompliant hospice programs, and require the development and implementation of a range of remedies as well as procedures for appealing determinations regarding these remedies. These remedies can be imposed instead of, or in addition to, termination of the hospice programs' participation in the Medicare program. The remedies include civil money penalties (CMPs), suspension of all or part of payments, and appointment of temporary management to oversee operations.

In the CY 2022 Home Health Prospective Payment System (HH PPS) final rule (86 FR 62240), we addressed provisions related to the hospice survey enforcement and other activities described in this section. A summary of the finalized CAA provisions can be found in the CY 2022 HH PPS final rule: *https://www.govinfo.gov/content/pkg/FR-2021-11-09/pdf/2021-23993.pdf.* We finalized all the CAA provisions in CY 2022 rulemaking except for the SFP. As outlined in the CY 2022 HH PPS final rule, we stated that we would take into account comments that we received and work on a revised proposal, seeking additional collaboration with stakeholders to further develop the methodology for the SFP. Since the publication of the CY 2022 HH PPS final rule, we have decided to initiate a hospice Technical Expert Panel (TEP) in CY 2022. Accordingly, CMS plans to use the TEP findings to further develop a proposal on the methodology for establishing the hospice SFP, and we plan to include a proposal implementing an SFP in the FY 2024 Hospice Wage Index and Payment Rate Update proposed rule.

We received several comments regarding the SFP. A summary of those comments and our responses to those comments are as follows:

Comment: Commenters were generally supportive of CMS's efforts to establish an SFP and convene a TEP to provide feedback on a potential methodology for identifying hospices in the SFP. Many of these commenters expressed support for the inclusion of a wide range of stakeholders to be considered for TEP with knowledge related to the hospice survey process including hospice staff who directly interact with patients and surveyors.

A couple of commenters encouraged CMS to forgo the use of a quota system, as utilized in the Special Focus Facility (SFF) Program for nursing homes, in the new SFP for hospices. The commenters recommended CMS consider a national centralized SFP selection methodology rather than deferring to state priorities or agencies. Other commenters expressed support for standardizing the survey process, including standardizing surveyor training, before fully implementing the SFP to ensure there are no variances to how entities conduct their surveys.

Response: We appreciate the commenters support for the SFP. We will consider the comments and TEP feedback as CMS develops the SFP methodology.

V. Collection of Information

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

VI. Regulatory Impact Analysis

A. Statement of Need

This final rule meets the requirements of our regulations at § 418.306(c) and (d), which require annual issuance, in the **Federal Register**, of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of CBSAs or previously used MSAs, as well as any changes to the methodology for determining the per diem payment rates. This final rule also updates payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2023 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. The payment rate updates are subject to changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. Lastly, section 3004 of the Affordable Care Act amended the Act to authorize a quality reporting program for hospices, and this rule does not change the requirements for the HQRP in accordance with section 1814(i)(5) of the Act.

B. Overall Impacts

We estimate that the aggregate impact of the payment provisions in this final rule would result in an estimated increase of $825 million in payments to hospices, resulting from the hospice payment update percentage of 3.8 percent for FY 2023. The impact analysis of this rule represents the projected effects of the changes in hospice payments from FY 2022 to FY 2023. In order to calculate the wage index standardization factor, we simulate total payments using FY 2021 hospice utilization claims data; in this case claims accessed from the CCW on May 10, 2022 with the FY 2022 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, without the 5-percent cap on wage index decreases) and FY 2022 payment rates, and compare it to our simulation of total payments using the FY 2023 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, with the 5-percent cap on wage index decreases) and FY 2022 payment rates. By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2022 wage index and payment rates for each level of care by the FY 2023 wage index and FY 2022 payment rates, we obtain a wage index standardization factor for each level of care.

Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this final rule is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act). Accordingly, we have prepared an RIA that, to the best of our ability, presents the costs and benefits of the rulemaking.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a RIA that, to the best of our ability presents the costs and benefits of the rulemaking.

C. Detailed Economic Analysis

1. Hospice Payment Update for FY 2023

The FY 2023 hospice payment impacts appear in Table 10. We tabulate the resulting payments according to the classifications (for example, provider type, geographic region, facility size), and compare the difference between current and future payments to determine the overall impact. The first column shows the breakdown of all hospices by provider type and control (non-profit, for-profit, government, other), facility location, facility size. The second column shows the number of hospices in each of the categories in the first column. The third column shows the effect of using the FY 2023 updated wage index data with a 5-percent cap on wage index decreases. This represents the effect of moving from the FY 2022 hospice wage index to the FY 2023 hospice wage index with a 5-percent cap on wage index decreases. The aggregate impact of the changes in column three is zero percent, due to the hospice wage index standardization factor. However, there are distributional effects of the FY 2023 hospice wage index. The fourth column shows the effect of the hospice payment update percentage as mandated by section 1814(i)(1)(C) of the Act, and is consistent for all providers. The hospice payment update percentage of 3.8 percent is based on the 4.1 percent inpatient hospital market basket update,

reduced by a 0.3 percentage point productivity adjustment. The fifth column shows the effect of all the changes on FY 2023 hospice payments. It is projected that aggregate payments would increase by 3.8 percent; assuming hospices do not change their billing practices. As illustrated in Table 10, the combined effects of all the proposals vary by specific types of providers and by location. We note that simulated payments are based on utilization in FY 2021 as seen on Medicare hospice claims (accessed from the CCW in May 10, 2022) and only include payments related to the level of care and do not include payments related to the service intensity add-on.

As illustrated in Table 10, the combined effects of all the proposals vary by specific types of providers and by location.

TABLE 10: Impact to Hospices for FY 2023

Hospice Subgroup	Hospices	FY 2023 Updated Wage Data With 5% Cap	FY 2023 Hospice Payment Update (%)	Overall Total Impact for FY 2023
All Hospices	5,253	0.0%	3.8%	3.8%
Hospice Type and Control				
Freestanding/Non-Profit	579	-0.1%	3.8%	3.7%
Freestanding/For-Profit	3,578	0.1%	3.8%	3.9%
Freestanding/Government	44	0.0%	3.8%	3.8%
Freestanding/Other	354	0.0%	3.8%	3.8%
Facility/HHA Based/Non-Profit	343	-0.2%	3.8%	3.6%
Facility/HHA Based/For-Profit	198	-0.2%	3.8%	3.6%
Facility/HHA Based/Government	77	-0.1%	3.8%	3.7%
Facility/HHA Based/Other	80	-0.3%	3.8%	3.5%
Subtotal: Freestanding Facility Type	4,555	0.0%	3.8%	3.8%
Subtotal: Facility/HHA Based Facility Type	698	-0.2%	3.8%	3.6%
Subtotal: Non-Profit	922	-0.1%	3.8%	3.7%
Subtotal: For Profit	3,776	0.1%	3.8%	3.9%
Subtotal: Government	121	-0.1%	3.8%	3.7%
Subtotal: Other	434	-0.1%	3.8%	3.7%
Hospice Type and Control: Rural				
Freestanding/Non-Profit	130	-0.1%	3.8%	3.7%
Freestanding/For-Profit	354	0.1%	3.8%	3.9%
Freestanding/Government	25	-0.5%	3.8%	3.3%
Freestanding/Other	51	0.1%	3.8%	3.9%
Facility/HHA Based/Non-Profit	133	-0.2%	3.8%	3.6%
Facility/HHA Based/For-Profit	50	-0.6%	3.8%	3.2%
Facility/HHA Based/Government	60	-0.1%	3.8%	3.7%
Facility/HHA Based/Other	46	-0.1%	3.8%	3.7%
Facility Type and Control: Urban				
Freestanding/Non-Profit	449	-0.1%	3.8%	3.7%
Freestanding/For-Profit	3,224	0.1%	3.8%	3.9%
Freestanding/Government	19	0.1%	3.8%	3.9%
Freestanding/Other	303	0.0%	3.8%	3.8%
Facility/HHA Based/Non-Profit	210	-0.2%	3.8%	3.6%
Facility/HHA Based/For-Profit	148	-0.1%	3.8%	3.7%

Facility/HHA Based/Government	17	-0.1%	3.8%	3.7%
Facility/HHA Based/Other	34	-0.3%	3.8%	3.5%
Hospice Location: Urban or Rural				
Rural	849	0.0%	3.8%	3.8%
Urban	4,404	0.0%	3.8%	3.8%
Hospice Location: Region of the Country (Census Division)				
New England	149	-0.5%	3.8%	3.3%
Middle Atlantic	282	0.2%	3.8%	4.0%
South Atlantic	592	-0.3%	3.8%	3.5%
East North Central	569	-0.4%	3.8%	3.4%
East South Central	258	-0.1%	3.8%	3.7%
West North Central	413	-0.4%	3.8%	3.4%
West South Central	1,030	0.5%	3.8%	4.3%
Mountain	548	-0.1%	3.8%	3.7%
Pacific	1,363	0.6%	3.8%	4.4%
Outlying	49	-0.3%	3.8%	3.5%
Hospice Size				
0 - 3,499 RHC Days (Small)	1,133	0.3%	3.8%	4.1%
3,500-19,999 RHC Days (Medium)	2,462	0.2%	3.8%	4.0%
20,000+ RHC Days (Large)	1,658	0.0%	3.8%	3.8%

Source: FY 2021 hospice claims data from CCW accessed on May 10, 2022.
Note: The overall total impact reflects the addition of the individual impacts, which includes the overall wage index impact of updating the wage data with a 5-percent cap on wage index decreases, as well as the 3.8 percent hospice payment update percentage which reflects the productivity-adjusted hospital market basket.

Region Key:
New England=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic=Pennsylvania, New Jersey, New York;
South Atlantic=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East North Central=Illinois, Indiana, Michigan, Ohio, Wisconsin
East South Central=Alabama, Kentucky, Mississippi, Tennessee
West North Central=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
West South Central=Arkansas, Louisiana, Oklahoma, Texas
Mountain=Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
P**acific**= Alaska, California, Hawaii, Oregon, Washington
Outlying=Guam, Puerto Rico, Virgin Islands

2. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on ~~last~~ this year's proposed rule will be the number of reviewers of this final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed ~~last~~ this year's proposed rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this final rule. We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule.

Using the occupational wage information from the BLS for medical and health service managers (Code 11–9111) from May 2020; we estimate that the cost of reviewing this rule is $115.22 per hour, including overhead and fringe

benefits (*https://www.bls.gov/oes/current/oes_nat.htm*). This rule consists of approximately 29,289 words. Assuming an average reading speed of 250 words per minute, it would take approximately 0.98 hours for the staff to review half of it. For each hospice that reviews the rule, the estimated cost is $112.49 (0.98 hours × $115.22). Therefore, we estimate that the total cost of reviewing this regulation is $8,211.72 ($112.49 × 73 reviewers).

D. Alternatives Considered

Since the hospice payment update percentage is determined based on statutory requirements, we did not consider not updating hospice payment rates by the payment update percentage. The 3.8 percent hospice payment update percentage for FY 2023 is based on a 4.1 percent inpatient hospital market basket update, reduced by a 0.3 percentage point productivity adjustment. Payment rates since FY 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent years must be the market basket percentage for that FY. Section 3401(g) of the Affordable Care Act also mandates that, starting with FY 2013 (and in subsequent years), the hospice payment update percentage will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act.

E. Accounting Statement

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), in Table 11, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this rule. Table 11 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this rule. This estimate is based on the data for 5,253 hospices in our impact analysis file, which was constructed using FY 2021 claims available in May 2022. All expenditures are classified as transfers to hospices.

TABLE 11: Accounting Statement: Classification of Estimated Transfers and Costs, From FY 2022 to FY 2023

Category	Transfers
Annualized Monetized Transfers	$ 825 million*
From Whom to Whom?	Federal Government to Medicare Hospices

*The increase of $825 million in transfer payments is a result of the 3.8 percent hospice payment update compared to payments in FY 2022.

F. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. We consider all hospices as small entities as that term is used in the RFA. The North American Industry Classification System (NAICS) was adopted in 1997 and is the current standard used by the Federal statistical agencies related to the United States business economy. There is no NAICS code specific to hospice services. Therefore, we utilized the NAICS United States industry title ''Home Health Care Services'' and corresponding NAICS code 621610 in determining impacts for small entities. The NAICS code 621610 has a size standard of $16.5 million.[33] Table 12 shows the number of firms, revenue, and estimated impact per home health care service category.

[33] *https://www.sba.gov/sites/default/files/2019-08/SBA%20Table%20of%20Size%20Standards_Effective%20Aug%2019%2C%202019_Rev.pdf.*

TABLE 12: NUMMBER OF FIRMS, REVENUE, AND ESTIMATED IMPACT OF HOME HEALTH CARE SERVICES BY NAICS CODE 621610

NAICS Code	NAICS Description	Enterprise Size	Number of Firms	Receipts ($1,000)	Estimated Impact ($1,000) per Enterprise Size
621610	Home Health Care Services	<100	5,861	210,697	$35.95
621610	Home Health Care Services	100-499	5,687	1,504,668	$264.58
621610	Home Health Care Services	500-999	3,342	2,430,807	$727.35
621610	Home Health Care Services	1,000-2,499	4,434	7,040,174	$1,587.77
621610	Home Health Care Services	2,500-4,999	1,951	6,657,387	$3,412.29
621610	Home Health Care Services	5,000-7,499	672	3,912,082	$5,821.55
621610	Home Health Care Services	7,500-9,999	356	2,910,943	$8,176.81
621610	Home Health Care Services	10,000-14,999	346	3,767,710	$10,889.34
621610	Home Health Care Services	15,000-19,999	191	2,750,180	$14,398.85
621610	Home Health Care Services	≥20,000	961	51,776,636	$53,877.87
621610	Home Health Care Services	Total	23,801	82,961,284	$3,485.62

Source: Data obtained from United States Census Bureau table "us_6digitnaics_rcptsize_2017" (SOURCE: 2017 County Business Patterns and Economic Census) Release Date: 5/28/2021: https://www2.census.gov/programs-surveys/susb/tables/2017/
Notes: Estimated impact is calculated as Receipts ($1,000)/Number of firms.

The Department of Health and Human Services practice in interpreting the RFA is to consider effects economically ''significant'' only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The majority of hospice visits are Medicare paid visits and therefore the majority of hospice's revenue consists of Medicare payments. Based on our analysis, we conclude that the policies finalized in this rule would result in an estimated total impact of 3 to 5 percent or more on Medicare revenue for greater than 5 percent of hospices. Therefore, the Secretary has determined that this hospice final rule would have significant economic impact on a substantial number of small entities. We estimate that the net impact of the policies in this rule is a 3.8 percent or approximately $825 million in increased revenue to hospices in FY 2023. The 3.8 percent increase in expenditures when comparing FY 2023 payments to estimated FY 2022 payments is reflected in the last column of the first row in Table 10 and is driven solely by the impact of the hospice payment update percentage reflected in the fourth column of the impact table. In addition, small hospices would experience a greater estimated increase (4.1 percent), compared to large hospices (3.8 percent) due to the policy to cap wage index decreases at 5 percent. Further detail is presented in Table 10, by hospice type and location.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. This rule will only affect hospices; therefore, the Secretary has determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals (see Table 10).

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2022, that threshold is approximately $165 million. This rule is not anticipated to have an effect on state, local, or tribal governments, in the aggregate, or on the private sector of $165 million or more in any 1 year.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. We have reviewed this rule under these criteria of Executive Order 13132, and have determined that it will not impose substantial direct costs on state or local governments.

I. Conclusion

We estimate that aggregate payments to hospices in FY 2023 will increase by $825 million as a result of the market basket update, compared to payments in FY 2022. We estimate that in FY 2023, hospices in both rural and urban areas will experience, on average, a 3.8 percent increase in estimated payments compared to FY 2022. Hospices providing services in the Pacific and West South Central regions would experience the largest estimated increases in payments of 4.4 percent and 4.3 percent, respectively. Hospices serving patients in areas in the New England region would experience, on average, the lowest estimated increase of 3.3 percent in FY 2023 payments.

This final regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to the Congress and the Comptroller General for review.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on July 22, 2022.

List of Subjects in 42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR part 418 as set forth below.

PART 418—HOSPICE CARE

■ 1. The authority citation for part 418 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 2. Section § 418.306 is amended by revising paragraph (c) to read as follows:

§ 418.306 Annual update of the payment rates and adjustment for area wage differences.

* * * * *

(c) *Adjustment for wage differences.* (1) Each hospice's labor market is determined based on definitions of Metropolitan Statistical Areas (MSAs) issued by OMB. CMS will issue annually, in the **Federal Register**, a hospice wage index based on the most current available CMS hospital wage data, including changes to the definition of MSAs. The urban and rural area geographic classifications are defined in § 412.64(b)(1)(ii)(A) through (C) of this chapter. The payment rates established by CMS are adjusted by the Medicare contractor to reflect local differences in wages according to the revised wage data.

(2) Beginning on October 1, 2022, CMS applies a cap on decreases to the hospice wage index such that the wage index applied to a geographic area is not less than 95 percent of the wage index applied to that geographic area in the prior fiscal year.

* * * * *

Dated: July 25, 2022.

Xavier Becerra,

Secretary, Department of Health and Human Services.

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